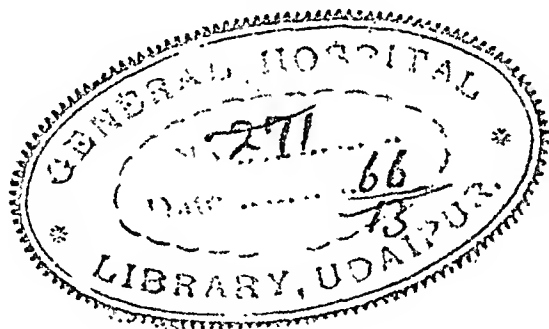


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Understandable PSYCHIATRY

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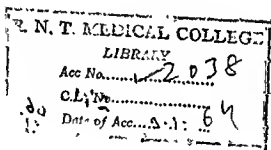
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To
my wife
and daughter.



PREFACE

The patient is the central figure in the practice of medicine, because he or she constitutes the only reason for the existence of physicians. This very naive truth places foremost responsibility for the maintenance of sound health upon the person who is already enjoying it and who, if he wishes to continue it, must keep abreast with accredited measures recommended by physicians. The more the person knows about himself or herself, the better is he or she equipped to realize the difference between health and disease.

The practice of medicine is a partnership between the person seeking information and the physician, qualified by training and experience, who gives it. The state of health of any community is in large measure a reflection of the teamwork done by the potential or real patient and the physician.

Years ago the patient, aware only of distress and having no knowledge of the possible origin and meaning of it, stood by mutely, while the physician examined and prescribed for him. Moreover, the former seldom imparted any information about the disease to the patient. Both were non-communicative; neither knew very much about the other. It was a partnership without sharing. While it remained so, neither gained as much as could have come out of the situation had each side given freely to the other. In those bygone days the patient yielded everything to the physician, while the latter, hardly from sheer selfishness, but rather out of regard for his own limited knowledge and sense of security, hoarded his learning.

Today the situation is quite different because the value of co-operation has been well established. People know more about medicine than they ever knew before, in the first place, because much more is known in general, but particularly because what is known is made available to people as facts to be acted upon in the interest of health, not as mere intellectual acquisitions. In the

practice of medicine, the patient is the central figure not only because he or she is ill, but also because he or she is the first one to become aware of the earliest signs of disorder. Clearly it is to the patient's supreme interest to be as familiar as possible with the origin and nature of the ailment, so that proper remedies may be immediately administered.

Psychiatry is a branch of medicine being made more accessible and more understandable to the profession and to the public at large. A very important phase of psychiatric consideration is right in front of us from the time we are able to use critical judgment. We see it throughout our waking hours, we look at it closely and attentively, we know its gross and microscopic anatomy, often we recognize the slightest deviations from the normal—it is our *personality*, made up of our inner and outer impulses, our likes and dislikes, our ambitions, our assets and liabilities. From the standpoint of being a human being among human beings the "we" part of ourselves is far more important to us than is the heart or liver or stomach. In other words, we have to look upon "*us*," as *the most important part of us*. Perhaps that is one reason why the "we" part of us is right out in plain view of ourselves.

Combining (1) the innate drives of mankind and (2) experiences dating from birth, the personality is our possession of greatest influence as regards our position in life as human beings. It is the aggregate of knowledge of *ourselves as selves* that constitutes psychiatry.

Psychiatry cannot succeed as a treatment procedure until the treated person with the physician's aid, comes to know as much about his or her personality as does the physician. That is why the contents of this book are addressed equally to the patient and the physician.

LELAND E. HINSIE, M.D.

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How Feelings Make Us Sick

Established facts in the realm of psychiatry are as understandable and as applicable in practical use as are those of any other specialty in medicine. In fact, they are more easily grasped by people in general than are the data on anatomy, physiology, biochemistry, pathology, etc., because the personality out of which psychiatry grows, is always exposed to investigation and understanding. We live with our personality, see it in everyday action; we plan what we want it to do for us; in short, the normal, healthy individual guides his thinking, acting and feeling to an extent that is not possible with any other functional system of the body. The statement that personality components are within reach of our conscious survey takes no cognizance of the enormous role that our inner life plays in our destiny, but it does stress the important fact that the personality is more completely open to observation and control than is any other part of ourselves.

In the new century in particular, practical results of research have built up the conviction that the growth of emotions determines to a very appreciable extent the kind of life we lead, our attitude towards our friends and subordinates, equals, and superiors, towards our social institutions, such as marriage, parenthood, the form of political, scholastic, economic, recreational, and religious life. We are endowed with emotions and are destined to live with them and to live very intimately until the day of death. There is no other human possession (heart, lungs, stomach, skeletal muscles, bones, glands, etc.) that we are more keenly aware of, that is as influential in determining our pursuits in life as are the emotions. In fact, is it

not true that the reason we keep on living is to be found in our emotions, which include our likes and dislikes, our successes and frustrations? Or to put it another way, no one lives in order to keep intact his malleus or stapes, his supinator or pronator, his histamine or creatinine, his red nucleus or substantia nigra. These, and thousands of other parts of the body, are vital to living, though most of us go through an entire lifetime without knowing of their existence and location or even their very name. We live for the person, for the personality, for the essential character which makes us what we are.

To many it may seem strange that physicians have taken over the care of a part of society that formerly was under the direction of leaders in religion, education, philosophy, and psychology. There is nothing unusual about this, however, because in centuries gone by physicians were largely concerned with the health and sickness of the obviously organic part of the individual. Even today that is true of the vast majority of physicians.

More than ever before physicians began to realize about a century ago that a large number of patients seemed to be sick with bodily ailments, and yet all the prevailing medical skills of the time failed to reveal an organic cause for the complaints. Only then it was that certain physicians began to hunt for information pointing to the possibility that sickness might also be the result of emotions beset with mental conflicts. The science of emotions was born. Physicians came to speak of a biology of the mind, as they had spoken of a biology of the body. The term *psychobiology* has since stayed in science.

Sick people, in whom no organic causes for ailing were found, began to flock to this new group of physicians. Both organic and mental medicine were relatively new at that time. Progress was rapid, however, and with improved techniques of examination physicians began to feel a little more secure in differentiating mental from physical causes. In so doing they attracted those patients who formerly looked to religion and philosophy for relief. It is not surprising that conflicts arose; whole sectors of society that had erstwhile sought solace in other fields placed themselves in the hands

of the new group of psychiatrists. This movement has been on the increase since it was initiated.

Great impetus was given to it by Sigmund Freud, the father of mental microscopy or, more appropriately, of *psychoscopy*. It was he who first dissected the mind—not the brain—as others had done to the sundry organs of the body. As no one else before him, he described the origin and development of the instincts, their manifestations in the body as well as in the mind. He proved empirically the 300-year-old Cartesian philosophy that the human mind is a thinking substance in intimate association with the body. The Cartesian conarium (the point of contact of mind and body) was renamed the *Id* by Freud, who regarded it as the place in which the instincts, both in their organic and psychic manifestations, are localized and from there spread to diverse sections of the body and mind.

Upon the introduction of Freudian concepts a larger proportion of distraught people, whose illnesses were essentially uninfluenced by organic techniques, sought remedy for their ills in mental treatment (*psychotherapy*)—and many of them succeeded. The practices have since steadily widened.

People had learned through the ages to come with their ills to the physician's office, but now most of them had no inkling that, failing to avail himself of this newer yet successful approach to illness, the average physician they went to confined his examinations to his organic facilities, assuming as he did for years, that what he had failed to detect was not yet detectable. Medicine had gone through an era in which it described whole clinical disorders as "functional" in the belief that, while the medical field was able to reveal structural changes in tissue, it had not yet developed competency in recognizing alterations in functioning. Physicians were, or should we say are, slow to use one of the most valuable efficient means for the understanding and treatment of many of these functional disturbances, namely, *psychiatry*.

Of course, it cannot be said that all functional disorders are emotional in origin, but from ample evidence we know that a fairly large number of them are. It is best, however, to keep an open mind

on the subject; and it certainly is a fault not to include scientific knowledge of the emotions in the examination and treatment of functional illnesses. The patient is entitled to both.

The medical profession assumes responsibility for the care and treatment of people whose bodies are plagued with feelings of sickness, but it should and yet it does not, distinguish between ills that are physically determined and those arising from mental causes. As we have already said, the mind is as much a part of the human being as is the heart or brain or stomach, and the emotions must be included among the many hereditary, congenital, bacterial, accidental, etc. causes of bodily distress.

Through a period of three years a man of 24 had been examined with respect to "an awful feeling of tension in the upper part of the chest." He had the sensation that "something" was about to explode within his chest, and he would then drop dead. All manner of physical skills and tests applied yielded no clue or inkling whatever. He was a forlorn individual, yet no physician had ever asked him how *he* felt, although full and exhaustive inquiry was always made as to how his chest felt.

Psychiatric examination revealed that he was a lonely fellow, and had always been so. He was a sort of emotional beggar, holding his mental palm out to people, yet always expecting it to be slapped down, and, in such anticipation, the pleading palm convulsively clenched into a fighting fist. He never fought, though—physically. Well-endowed as he was intellectually he whetted a venomous tongue inlaid with scholarship. For years that tongue was his well-nigh exclusive means for meeting people. As he himself put it, he had to be either fiery, or "a simpering, drooling fool" as his only alternative.

He was, and always had been, tense. Now, tension can be experienced only as a physical sensation. However, when we asked what made him tense, he sharply retorted that anyone with his bringing up could not help being tense. His mother and father hated him. The first acquaintance with the world to which he was introduced, particularly by the mother, was a violent one. She mouthed her antagonism at him. He had no recollection of her ever

being kind to him, save in later years, when his intellectual achievements made her praise, not him, but the brilliance in him. He who yearned for affection saw it given on odd occasions to the honors he won.

A kindly person at heart, his father was vicariously quarrelsome under his wife's influence. It was plain that he wanted to be cordial to his son, but his wife prevented any show of affection between the two.

In the family there was another son, a feeble-minded boy, to whom the mother gave kind and constant attention. Recognizing the superior position he occupied in his mother's esteem, this boy literally rode roughshod over the patient, a situation that gave rise to utmost bitterness on the older brother's part. To him it was disgraceful, "thoroughly unfair and indecent," to know that feeble-mindedness was the means by which intimacy to the mother was gained. Throughout childhood and adolescence, emotional conditions in the family grew worse, particularly because the high esteem gained by the patient from his school teachers brought only resentment from his mother. Sometimes he accidentally found out that his mother spoke highly of his scholarship to others and he was led to believe that she used his achievements as a cover for his brother's incompetency.

The patient worked assiduously in the classroom, hoping against hope that eventually his mother would come to give him some kindness or at least would raze the barrier she had erected between her husband and son. Often he wanted to act as an imbecile, for he reasoned that then his mother would love and care for him.

When he first came to the psychiatrist for treatment, he took special pains to emphasize and re-emphasize that the unbearable tension in his chest stopped all his thinking, making him utterly imbecilic. He, a young man whose insatiable pleasure in practicing the art of reasoning led him to fountains of knowledge which created only thirst, he was on a raft in mid-ocean.

It was sickening, he said, to think of being just like his feeble-minded brother. Indeed, he was his feeble-minded brother; he was a hapless, inane fellow. Being in his brother's place obviously gave

him the only count for which he envied his brother, namely, the mutual fondness between his mother and brother.

While in the lives of children there are other influences that cause warped emotions, a loveless infancy and childhood stand out as the equal of any, and dwarf most of them. *A child who does not love and is not loved is lost, not alone in childhood, but throughout the subsequent years.* Outside the parents, but especially the mother, there seems to be no one with whom a child can live out, far into adulthood, the love that nature primarily destines for the parents. He tries and tries, but the newer companionships always leave something wanting. Our patient was never a boy to boys, a man to man. He often play-acted the role that he thought befitted his station, but paid dearly with his emotions for the make-believe. On the other hand, it was just as costly an outlay of emotion when he assumed an attitude of subordination to those whom he rationally described as inferior to him. He had a third method of meeting people, by belligerency, by bellowing at them. He never developed any one of the three reactions to the point at which it could be regarded as a habitual pattern, because he felt a revulsion from each of the three.

Nor were his associations with girls or women any more gratifying. With a huge-meshed lace of words that formally denote a kindly interest he hopelessly strove to veil his hatred for them. He doubted whether he ever misled any of them into believing that he cared for them. If any had been so naive as to have believed him, he wanted to go back to them to vent his spleen.

It was this sort of a person who had the horrible tension in his chest, who felt that he was a luckless imbecile, fallen from what adult security he had gained through intellectual achievement. He was no better off than his incapable brother. Yet, underneath it all was the grim, tragic awareness that, were he like the brother he would be in the brother's position with respect to his mother. "Fate" had decreed that some day the love, deeply repressed within him, would make itself felt at any cost. It did. It appeared in the guise of physical and mental torment, combined with excessive love for the mother-image within him: Promethean love, because of which the

father, Zeus, chained him to a rock and tortured him with a vulture. Quarles (Emblems, IV, 14) expressed it thus:

"These vultures in my breast

Gripe my Promethean heart both night and day."

It should be known that this person was not regarded by his friends and associates as a "mental case." He was different, to be sure, yet he was an excellent student, a young man steadily progressing towards his professional goal in life. He was graduated from college with honors, in the meantime being a leader in several academic organizations. He grew up, chronologically, physically, intellectually, but he remained an emotional dwarf. He was a textbook, not a human being; he was a man without a human country, exiled to the Siberia of scholarship, destitute of the warmth of human relationships.

Without entering at this stage into any academic discussions about finer details, it can be said that the physical complaints, so distressing to him, represented excruciating emotional tension consequent on the futile life he was living. Though quite different from organically-conditioned pain, emotional pain is nevertheless just as disturbing and incapacitating, and is just as real. Those who call it imaginary are correct in using that term, if they mean that it stems from the imagination of the patient. "Imaginary" is merely a designation pointing to its origin, but by no means registering the force of the pain.

While some initial difficulty may be experienced in distinguishing organic from mental pain, there are many ways in which the two differ. Until recently the discrepancies were recognized largely by psychiatrists, other physicians stopping their examinations after they felt that the pain was not organic. Many physicians then concluded that it was functional, thereby implying that it was still organic, though incapable of accurate detection. They defended their thesis with intense enthusiasm, though totally unable to adduce any organic proof in support of their claims. It was unfortunate, too, that they who championed the organic cause without a

semblance of proof, pooh-poohed the concept of emotional pain, because it was not provable organically.

This inconsistency has been cleared up to an appreciable extent, because *today the capable diagnostician can rule in emotional pain by positive direct evidence*. He no longer has to believe a condition to be functional, because it is not organic. He can know within the limits of current skills that it is mental by virtue of positive information, this in spite of the fact that there are still finer points to be cleared up between organic and mental functional manifestations. We should be as free to use what we know as we are to acknowledge what we do not know.

Using the patient's "horrible tension" in the chest as an illustration we have many positive reasons for considering his physical complaints as directly associated with emotional phenomena.

Emotional Pains

Emotional pains have characteristics of their own. This most important fact has been clearly recognized for years by psychiatrists. To be sure, this method of approach includes the ruling-out as well as the ruling-in process. It can be done as easily, though not as thoroughly, by the patient as by the physician, especially when he takes into consideration the several facts about to be discussed. With specific reference to the problem at hand in the preceding chapter, let us first see what the complaint was.

During the first three years of his trouble, our patient told physicians he had "pain" in the upper right side of the chest in front. The "pain" was more or less constant, varying from bare perceptibility to great intensity. Every physician took it for granted that when the patient said "pain" he meant pain in the popular sense. There was certainly no reason for believing the patient to be misrepresenting. He was an honest, sincere fellow, without any overt reason to hide behind an organic condition in order to avoid some current situation that he did not care to face squarely. However, a little examination into the complaint of pain would have revealed, as it later had, that it was a "peculiar" type of pain. It was not at all like the pain he had experienced with tooth trouble. Nor was there much resemblance to the pain of appendicitis or of pleurisy or of a large boil. The pains of those disorders were sharp, localized; "they were tissue pains," as he said. He could point to the pained areas. Besides, they bothered his body.

Indeed, the "pain" was not a pain. He described it more accurately as a tension, analogous to the sensation of butterflies in the stomach often experienced when one gets "nervous" in a new sit-

uation. It was like the physical sensation of a lump in the throat, so commonly observed as a concomitant of sudden fright. In feeling, it was not unlike what he conceived to be a sense of loneliness in the chest of the lover whose sweetheart is not nearby. Psychiatrists have a name for it, *psychalgia* (mental pain), distinguishing it from organic pain or *somatalgia*. His was not organic pain.

Anyone could have found that out—that is, anyone who cared to take the time and trouble to do so. This is such a fundamental line of inquiry that it should never be omitted. When we start on the wrong assumption, our subsequent examinations are likely to give misleading or puzzling results. It is detrimental to the patient to overlook such basic examination.

It is hoped that the lot of the psychiatrist, but more particularly of the patient, will be made easier as a result of correct first examinations. We still get too many patients who for years have been taken over the organic realm of medicine unnecessarily and with symptoms essentially unaltered. Certainly we do not have the full and final answer to the origin and development of the ills to which the flesh is exposed, but there is no sound reason not to use what we know to be helpful to the patient. It is not a theory that many mental problems are preventable; they are—with current skills. But many are not, and those will be discussed in later sections of this book.

For purposes of emphasis it should be repeated that *emotional pains have more or less specific characteristics*, one of which is their close resemblance to what is popularly known as *tension*. Too frequently the correct designation is first made by members of a patient's family or by his associates, but too often also the patient "forgets" it, when he enters the physician's office. This type of forgetfulness is associated with the patient's unwitting tendency to ignore the true nature of his complaints.

Emotional pains frequently baffle examination. It sounds peculiar to ascribe defiance to emotional pains, yet very often the physician meets obstacles to the simple examination of their qualities. Possibly that is one reason why physicians do not investigate the details of

an emotional pain; the patient indicates his displeasure and physicians are notoriously kind to symptoms, if not to the patient. Another unwitting ruse that turns the physician away from further examination of emotional pains is the patient's inability to give further description. Moreover, the patient may be, very often is, afraid to know the truth about the origin of his pain, because then he is faced with the need for going still more deeply into his emotional life. The truth is by no means easy to face. In fact, at first it almost always appears more troublesome than the symptom behind which it is concealed. Deleterious as our patient's chest symptom was, the uncovering of the cause produced a more violent, though temporary, reaction. *Emotional pains are casings for explosive materials.*

No wonder, then, that there is reluctance to detailed inspection of them. There is the dread that what lies behind is more intolerable. This most important fact helps to characterize the examination of emotional pains. It surely has no parallel in the investigation of pains due to organic causes. In the latter instance the patient is pleased with the thoroughness of the physician, to whom he is unstinting in giving information.

Often it is unfortunately unwise—we hope that this condition will soon disappear among physicians—to have any pre-conceived notions as to what may be uncovered, because then the patient senses that you are going into his emotional life and under these circumstances, his unconscious resistance may block further examination, unless he is psychologically prepared. Moreover, you are only striving, without prejudice, to get a description of the symptom. Your impression of its significance is derived from a survey of the facts. The capable physician is first an inquirer.

The general practitioner whose office is jammed with patients is not to be envied. He does not have time to get the most important clues to the illnesses of many of his patients. He cannot take the time required for an examination of the history of the patient's sickness, *the history often having greater bearing on the diagnosis than physical tests have.* It would be helpful to have the family doctor back for at least one reason—he used to sit down in the easy chair,

asking gently how the illness started and how it appeared with the passing of time. Of course, he did not have a modern laboratory to which he could send the patient for a great variety of tests. He had to rely on the history of the sickness as well as on the few physical assets he possessed. This is not a plea to go back to him, not at all, but it is hoped that his facility for history-taking might be incorporated into modern scientific methods.

The organic distribution of emotional pains ordinarily does not correspond with anatomical structure. One of the simplest examples of this kind of discrepancy is the so-termed glove anesthesia, meaning that the absence of sensation extends over an area roughly covered by a glove, a condition not known in organic diseases of the nerves. It is the patient's mind that creates the deadening, as if he said to himself that since the hand offends him he psychologically cuts it off. *The hand is one of the outstanding representatives of the emotions.* We speak of the heavy hand in states of oppression, of the slack hand denoting idleness, of the helping hand of cheerfulness and co-operation, of the light hand of gentleness, of the strict hand of severe discipline, of the strong hand of force, of the hand-in-glove of familiarity, of the hand over head of negligence, of the black hand of lurid crime, etc. Human qualities find luxuriant expression in the body. To get excellent examples of psychosomatic states we need only to refer to the classical literature from which we can cite endlessly the representation of entire character traits in a given part of the body. To make *head* against is to withstand effectively. Milton referred to "the contemptuous brow." Bacon spoke of men counseling "with an eye to themselves." Prior inferred a state of discord in the phrase "by the ears." To turn up the *nose* is to express scorn and contempt. To give one the lie in his *throat* is to accuse one of outrageous lying.

This random sampling is but a fraction of the psychology given to parts of the head. These multiple expressions of emotions in terms of the body are real and forceful; people live by them; we make our bodies not only speak for us, but feel for us. *Our bodies are the only medium through which we can communicate ourselves as human beings.* Save the organs of the body, there are no other

channels for ideas and feelings to flow through. This fundamental doctrine is the keynote, not alone of psychological medicine, but also of psychological health. Without this concept we cannot understand, let alone treat, the fearfulness that blanches the skin, makes the heart rate go up to abnormal heights, tenses and weakens the muscles of the body, and creates the sensation of imminent collapse. We cannot grasp the influence of sadness upon the gait, posture, facial expression, dullness of the eyes, tearfulness, dry throat, loss of appetite, faulty digestion and elimination, and confusion. In their effects emotions are as powerful as are organic elements in inducing sensations in the body.

To appreciate the significance of the interrelationship between the mind and the body, let us see in part the role that the heart plays as the spokesman for the emotions. It must be understood clearly that what follows is not at all an essay in philology. It is a demonstration of one of the sciences of medical practice, as concrete in its application as is the blood pressure apparatus and the medicines given to influence heart action.

Bushnell wrote: "The life of a man is in his heart, and, if he does not live there, I care not what other success may befall him, he does not live."

"He who has no heart of his own cannot reach mine and make it feel"—W. M. *Punshon Lectures*, Macaulay.

"What his breast forges, that his tongue must vent"—Shakespeare.

"Her heart was too full to speak"—Trollope.

"Thy dauntless heart will urge thee to thy fate"—Dryden.

Expressions in English referring to the heart are many. At heart = in the innermost character; for one's heart = for one's life; from one's heart = sincerely; in one's heart = inwardly; in tedious heart = in anxiety; out of heart = discouraged; to do one's heart good = to make one feel better; to have a heart = to be merciful; to have at heart = to cherish; to have in one's heart = to purpose or plan; to have one's heart in one's boots = to be greatly depressed, as by terror; to have one's heart in one's mouth = to be frightened; to have one's heart in the right place = to mean well; to make the

heart bleed = to cause extreme anguish; with all one's heart = very earnestly; by heart = by rote; to find in one's heart = to feel willing; to lay to heart = to think seriously about; to break the heart = to crush with sorrow; to cry one's heart out = to cry to exhaustion; to eat one's heart = to pine away from longing; to have heart = to be courageous; to take heart = to pluck up courage; heart of hearts = one's innermost feelings; heart and soul = the whole of one's energies and affections; heart to heart = of great intimacy and sincerity; to wear one's heart upon one's sleeve = to expose one's feelings to everyone.

Under the term "*-hearted*" Webster's *New International Dictionary of the English Language* (Second Edition, 1939, p. 1151) lists ninety-six different combinations, such as basehearted, chickenhearted, darkhearted, emptyhearted, fainthearted, greathearted, highhearted, ironhearted, kindhearted, leadenhearted, marblehearted, narrowhearted, openhearted, plainhearted, roughhearted, singlehearted, tigerhearted, whitehearted, to cite only several of them.

The value of the heart as an organ of language is certainly equal to that of the heart as an organ of the emotions. As actually practiced in the physician's office, modern psychiatry clearly recognizes the use to which patients put their heart in the matter of hiding their true emotions from themselves. The heart can be, and too frequently is, the terminal for one's pent-up feelings. Upon losing her son, a mother can put her courage in her intellect and her grief in her heart. Not wanting to suffer the grief, as such, she is inclined to regard her heart as organically unsound. The heart becomes the scapegoat for her anxieties and she interprets the palpitation and weakness as signs of organic trouble. The soldier, about to face the enemy's guns, diverts the dread to his heart and, by collapsing, avoids death. A hypochondriac, whose mother until her death pampered his "heart" condition, marries a substitute for his mother in order to retain the emotional bonds that had been established in and continued from the age of childhood. Through the "heart" condition he perpetuates his sonhood. Unconsciously emulating her mother, a daughter suffers from a fear of heart failure: whenever

her mother wanted obedience from the daughter, the mother acted as if she were about to die in a heart attack.

Today physicians are well aware of the fact that the heart can be unfavorably influenced to bear the brunt of a disordered mind. The mind is an imposer. It lays its burden upon the heart (or other organs). To say that the mind is an escapist is to tell the truth about one of its traits, namely, fraud—fraud that deceives the patient and others but not the heart—for all physical examinations are negative.

We need not go into as much detail about the role of the stomach and intestines as conveyors of emotions as we did about the heart. We hear it said that "he has no stomach for controversy." Motley spoke of the citizens who "had apparently no stomach for the fight." Stomach is synonymous with spirit, temper, heart. "This was no small Magnanimity in the King, that he was able to pull down the high Stomachs of the Prelates in that time" (Baker, *Chronicles*). It is synonymous with courage. Sir T. More in *Utopia* referred to "men of stouter stomachs." Stomach is also equated with compassion, pity, as in Chaucer's "Stomak ne conscience ne knowe I noon"; with pride and conceit—

"He was a man
Of an unbounded stomach, ever ranking
Himself with princes."

Shakespeare, *Henry VIII.*

Stomach is synonymous with anger, resentment. Milton advised against condemning "all things that are sharply spoken, or vehemently written, as proceeding out of stomach, virulence and ill-nature" (*Church-Government*, ii).

As a verb *stomach* not infrequently means to encourage, to hearten, to bear without open resentment, to disgust, to be or become angry.

The body is imprinted in the mind, the mind is stamped in the body: the two are inseparable—indeed, they are interchangeable. Emotions can be expressed (i.e., "forced out by pressure") through postures, gestures, grimaces; through the eyes, nose, mouth, skin,

throat, heart, lungs, stomach, intestines, etc. Body language is as old as man himself; it is the man in the body. It has cons of experience behind it. It is just as rich today as it was when man was primitive. We have learned how to re-enforce it with words. We have learned, to our sorrow, how to use it surreptitiously to give vent to those hidden feelings that we dare not speak out in clear words.

The heart and stomach were alluded to in the foregoing as examples of body organs that often take the responsibility for holding and transmitting emotions. Very few organs of the body, however, are free from such an assignment. For the present we are interested in the doctrine that organ language and feelings are natural, normal functions of organs of the body. Too commonly we assume that the mouth is the only outlet for the flow of ideas and feelings. It is a fact, too, that organs receive, and retain, both pleasurable and painful experiences and their accompanying emotions. The retention of such emotions by the organ has no discoverable correspondence with the anatomy of the organ. Nor is emotional energy in an organ to be confounded with the organic energy that is there to run the tissues of the organ.

The Oneness of Mind and Body

Body organs may harbor both ideas and emotions. This concept is but a corollary of the foregoing discussion, for the very simple reason that emotions are always linked up with ideas and experiences. A person is never afraid without being afraid of something which is registered in his mind. He is never happy or sad or angry *per se*, but he is so in connection with an idea. Therefore, since emotions flow into organs, so, too, do ideas. This concept is of tremendous practical significance in psychological medicine, because *patients frequently store their personal experiences in organs*. There should not be anything novel about this notion, because it is a commonplace observation.

First, let us see this principle in its simplest forms. When an infant utters its first word or embryonic sentence, the parents concentrate their attention on the child's mouth, thus also drawing the child's interest to that body area. The effects of praise or approbation attendant upon mouth movements in forming words and thus as vehicles for ideas are usually enormous. For years following, therefore, ideas and emotions are intimately connected with the mouth. If the parents show displeasure at the child's speech, the oral zone may become disliked by the child, so that later he may conceal the real or imputed inferiority behind mutism or scanty speech, or, perhaps, stuttering. *A child cannot use well or be inclined to use what the parents condemn.*

The same principle of the incorporation of ideas and feelings in parts of the body applies to almost all of the child's behavior. Parents who set an exceptionally high import upon body cleanliness may very well condition the child to matters of ultra-cleanliness,

to the point of inducing neurotic cleanliness. Some parents procure the child's cleanliness through praise, others through cajolery, still others by mental or physical force. The important feature of this process lies in the fact that sometimes the skin becomes imbued with ideas and feelings, to such an extent that it loses its tissue value to the child and acquires the distinction of a character trait. We merely need to know that a "skin" is a mean, stingy substance. We say a person does something with a whole skin, that is, with impunity. We save our skin when we come off without injury. To skin is to fleece, plunder, rob, cheat, abscond. These and other examples emphasize that the skin is not simply a covering for the body. It is infiltrated with emotions, some pleasant, some disagreeable. Certain people live largely for their skin, giving it more attention than they confer upon learning, sociability, etc. Perhaps, it is their main source of livelihood. At least to some it is their personality, heavily laden with experiences and feelings.

A child's movements, that is, the use of its muscles, may be steeped in ideas and emotions. Parents often stress posture and mobility, first in matters of standing upright, of handling toys and food implements, later of athletics, gracefulness, etc. *Some of the intense feelings of superiority and inferiority are related to body agility or the absence of it.* Many professional athletes live largely through their muscular system.

All of this means that the body is an excellent repository of the life interests of the individual. It is adapted to receive and to retain experiences and their emotions. This is a very trite observation and it would not be mentioned at all, if it were not for the fact that the body is so often found to be the vicarious channel of illnesses for which patients seek relief through physicians. Perhaps this misuse of the body is the greatest single cause of discomfort ranging from unhappiness to the sensation of definite organic disease. It is more destructive in lowering the efficiency of a lifetime than are bacteria or injuries or the wear and tear of the materials of organs.

Organs that even to us, who own them, are as invisible as to outsiders and—save when not functioning well—are to us as detached as they are to others, acquire unique distinction as scapegoats

for our likes and dislikes, our philosophy of living, our personality's strivings. The very fact that they are hidden from view gives them undeserved eminence, often to such a degree that we come to know certain people as stomachs or intestines, or hearts, or lungs, or sexual organs. As one patient put it: "I don't think with my mind, because my stomach has taken over that function." We know people whose "middle name is exhaustion," as another patient said. It almost came to be his surname, for it was a family trait. Weakness of emotional origin is not uncommon, and the fear of disease is usually more incapacitating than disease itself would be.

The lay public is barely beginning to realize that the turmoils of life may be lived out through the organs of the body. In a desperate effort to emancipate herself emotionally from a doting father, a young woman felt she had to marry, though she knew all too well that she was incapable of loving anyone but her father. He was the only man with whom she had ever shared her deep feelings. She had made a few half-hearted gestures towards two men who seemed to solicit her interest, but she quickly withdrew from their company. In her place of employment she was known as an efficient worker. Indeed, she was dubbed "efficiency." A man old enough to be her father casually took her to lunch one day. She was both scared and pleased. Other luncheons followed, then dinner. Later they held hands in affection, a situation that threw her into dire panic.

She began to socialize their relationship by steering him to crowded public places, in which at best or at worst nothing beyond hand-holding was possible. Then came the process of intellectualizing their companionship. For a long time they visited museums, libraries, and theatres, and the topics of discussions grew very academic. She could not, however, control her instincts as she did her intellect. Finally, and with deep sadness, she accepted his proposal of marriage.

Although by the skill of reasoning she had convinced her father that she would be happier if married, she knew that she would not be so. She could not dispel the dread that she was jilting her father, that in marrying she was entering into an unholy alliance. Maybe

she could come to love her fiancé, she thought. Over the months the thought, but not the emotions, possessed her, until finally swayed by reason she married him.

During the first year of married life she clung tenaciously to the idea of sharing life with him. To tide over her spells of despair she drew heavily upon play-acting, to which she was amply accustomed. But tensions mounted in her, until they grew almost unbearable. Loss of appetite, of weight, of sleep, a tiredness that could not be overcome, gripped her firmly. Because of her symptoms she could no longer go to their usual places of diversion; nor could she visit, or be visited by, friends. She was truly a very sick person, practically bedridden.

The skills of outstanding physicians were of no avail in helping her, because they were directed only to the organs of her body. When, however, she was investigated from the standpoint of psychiatry, it was evident that her course of life, the futility of living without the older attachments was taking its toll in the form of physical incapacity. Early in the development of her illness she realized the connection between her nervousness and its physical concomitants, yet she tried not to see their interconnection. As she grew sicker, her husband became more attentive to her. How, she reasoned, could she be so insincere, so base, as to conceal that her marriage was ill-advised from the very man who was now more than ever devoted to her? Remorse drove the nervousness from her mind and into her body, from which new location it plagued her almost beyond the state of tolerance. She lost sight of the fact that the deleterious influences stemmed from her mind: they seemed like a physical disease—her body not her mind tortured her now.

This is an example of the vicarious displacement of an entire series of personal experiences upon the organs of the body. It is not a new idea by any means. A body is a person, a human being, a somebody.

"For of the soule the bodie forme doth take
For soule is forme, and doth the bodie make."
Spenser, *Hymne in Honour of Beautie*. I, 132

What truth there is in the lines of Burns taken from *The Two Dogs*:

"But human bodies are sick fools,
For a' their colleges an' schools."

All that has been said above was put concisely by Shakespeare when he penned in *Midsummer Night's Dream*, V, I:

"As imagination bodies forth
The forms of things unknown."

Our forefathers had remarkable perspicacity, yet for centuries the doctrines they preached were not put into practical service, not until Freud applied them to patients. Now we see clearly how the "imagination bodies forth the forms of things unknown" and *we have ways of knowing what the unknown things are that the mind brings forth in terms of the body*. The concept is put to daily practice in the office of the psychiatrist. It is as indispensable as his stethoscope, blood pressure apparatus, and the great array of laboratory tests.

A woman of thirty-five had been suffering intense headaches for about a year. Repeated physical examinations gave no clew to the origin of her trouble. She looked like "the picture of health"; neither her husband nor friends could offer any suggestions for the headaches, though they surmised that perhaps they were due to the tensions of living. She was a tense person, though her general activities were few and she never hurried. Even superficial observation showed that she was a kindly person, fond of her home and husband, congenial with others and a popular member of several organizations. She often stressed the wholesomeness of her life in general and of home life in particular. As she recited details of the latter, it became clear, not to her however, that her husband provided richly for her, save in the matter of affection and emotional consideration. Without appreciating its momentousness to her she described him as a typical bachelor, which he had been until the age of forty-three.

He did not dislike women: they were pleasant companions for casual conversation and he was always polite and gentlemanly. But,

for pleasurable recreation he chummed with bachelor friends. He had always said that he did not want to be tied down to anyone, that he preferred to move around his living quarters without being obligated to anyone. He felt that he would inwardly resent keeping appointments that a wife, for instance, might make for him or the two of them. When he was ready to leave the house, he wanted to obey only his own urges. It would irk him, he thought, to wait for a wife, when he was ready to use the lavatory for shaving. He was thoroughly resigned to bachelorhood from the intellectual point of view, but as the years went on he began to feel the power of human nature in him. He still enjoyed his bachelor friends, took his vacation each year with them, yet something was missing. He was getting lonely, uneasy. Upon the death of his mother, who held him in great esteem, his loneliness grew, though it was well-concealed from his associates.

The woman, whom he was later to marry, he met at a gathering of friends. She was a cordial, warm person, a good conversationalist, but, above all, she was honorable and well-mannered. He wondered why she, at thirty-two, was not yet married, particularly since she was good-looking, of cheerful disposition and intelligent. He observed that she was not using the evening for its flirtatious possibilities. Indeed, she met his ideal of what a wife and mother should be in a gathering of friends.

He began to inquire about her more closely. She was the only girl in a family of five children and she was the youngest of the five. The family was closely bound, with six people as her guardians. Under family guidance she became a little lady in early childhood and an adult in late childhood. She had been given the privileges of private school education, had been tutored in a number of sports, and she moved in a variety of social circles. She was groomed for the best a girl could expect. Her future husband also found out that throughout adolescence and adulthood she had continued to maintain varied interests.

What the fiancé did not see, because he could not see it in himself, was the fact that, in a certain way, she was just as emotion-bound as he was. He knew, in an intellectual way, that she was a family

girl and, for that reason, he cared the more for her. He could not sense the invisible bonds that secured her to her family and them to her. The bonds were obscured by the unreserved freedom with which she moved about, but more particularly by the courteous welcome with which all members of her family accepted him.

He was a gentleman; she was a lady. On all sides the match was approved. Later they married. To their friends they were the ideal couple. They knew all the amenities by rote, and by repetition they learned how to make affability appear sincere. Neither one was the least bit hypocritical or dishonest, certainly not from the conscious point of view and to all intents and purposes they were correctly assumed to be happily adjusted. Later they were to become the unwitting victims of themselves as well as of each other.

From a frank discussion of their lives it became evident to the psychiatrist that the wife moved into married life with the only emotional equipment she knew, family love. She was well-schooled in the matter of kindness from her mother, father, and brothers. She was totally unlearned in sharing love and affection with others. She was a daughter and a sister to her husband. Marriage simply brought to her an additional father and brother.

Nor were there any essential changes in the husband. He gave wonderful lip service to his wife; she to him. Yet neither was to be blamed for this superficial alliance. Consciously they were honest.

The husband did not find it at all difficult to retain close companionship with one of his bachelor friends. Indeed, from the first few days of married life the friend was a frequent visitor at their house, coming in without appointment and acting almost as if their home was his home, too. If there was any doubt about it, the husband's behavior generously supported that of his friend. Their conversations seldom included her; they rarely opened up a topic in which she could participate. Her brothers at least acknowledged her presence by asking her what she thought of this or that, but the best she could hope for from her husband was a warmly expressed compliment of her tolerance, re-enforced by a cheerful pat and a kiss.

Forbearance! The idea was written indelibly all over her. Yet,

she reasoned that he was a kind husband; he did not intend to be inconsiderate, even, when, on not a few occasions, he called from the office to ask her kindly and lovingly, whether she minded if he went over to the bachelor's home for dinner and perhaps a conversational evening. Dinner was on the stove, but she did not tell him so. They ended the telephone conversation with evident cheerfulness.

To her half-hearted satisfaction she even rationalized the fact that her husband made all arrangements for and completed a three weeks' vacation with his friend, informing her of all the plans and calling her every other evening by phone later, while he was away. She never let him know a thing about this, the deepest wound she had ever had.

But, when he came to plan the next year to do the identical thing, she had a heart to heart talk with him: he was greatly surprised and remorseful to know that his plans hurt her. Now she felt that she had done him an injustice by telling him of her feelings; she reasoned that she did not understand him: husbands do take vacations without their wives. The fact that she knew only one or two who occasionally did it was entirely convincing to her. She conveniently overlooked the circumstance that the husbands in question were husbands of years' standing. She convinced him with kindness that he should not change his plans—he did not.

Shortly after his return her headaches set in and continued daily. He drew a little closer to her, though for a long time she did not let him know she had terrific headaches. He had to find out by detailed questioning, and at that she made light of her troubles.

Without his knowledge she went to many physicians for examination and treatment. It was not until she had gone to the psychiatrist for two months that she told her husband what she was doing.

She was treated, of course, by psychotherapy, as a consequence of which she possessed a full inventory of her life experiences and their significance to her and to her headaches. Her husband came to know what was essential for him to know, both about himself and her. The headaches disappeared and so did the tensions under

which they both lived, but which they had concealed from each other.

Experiences and emotions are embodied in us. When we try to drive them out of our minds, we often succeed only in banishing them to the unconscious part of our mind, from which spot they are freer to create havoc than they were when exposed to us. The more forcefully we exclude them from consciousness, the more readily are they pressed into the tissues of our body, appearing then as body sickness.

Regressive Living

With the knowledge of mental states at our disposal today it is possible to outline with relative clarity many functions of what we call the mind. Those functions can be felt very decisively by the individual. No one hesitates to acknowledge the influences of the feelings of happiness, sadness, irritability, fear, etc., for they are as real as is any feeling from an organ of the body. Not only can they be felt as organic manifestations, but they can be vividly "felt" as sensations apart from the tissues of the body. When, however, we sense their presence in the mind, we commonly say that we perceive (*per*, thoroughly + *capere*, to take = grasp) them, although we do not yet know through what we take in the feelings. For want of data for a better understanding and also, because there seems to be some plausibility to the idea, it is said that the functions of the mind are connected with the brain.

It is one of the unsolved problems of human nature to have such personal and intimate familiarity with the *functions* of human nature and yet not to be able to enclose those functions in an organ. In spite of this handicap we are in possession of a truly workable set of facts regarding the operations of the mind, to the extent that those who work constantly with the evidences of mental activity have no doubt about their practical value in conditioning people's lives. No one questions for a moment the scientific phenomena associated with electricity; it is something that cannot be seen, yet can be bent in many directions to the will of man. *In like manner, the powers of emotions can be put to multiple uses and are subject to laws governing their origin, growth, distribution, and expressions of intensity, even if we cannot put our finger on them.*

From what has been said it is clear enough that the vast amount of mental material with which we deal is largely the effect of our emotions, which have the unique facility of infiltrating not alone the body but also that other extremely large and powerful possession, our mind. Like all other parts of us, the mind is linked with the remote and recent past—that is, *at birth is laid down the pattern of the mind containing what is collectively known as the instinctual life of the individual.*

That this is not theory, that the mind is a composite of actions, feelings and ideas that are vividly discernible in the life of the individual is demonstrable in certain classes of patients who come for treatment. This idea is going to be exemplified under the heading *schizophrenia*, but we want to state a few facts also here, in order to indicate that man has within him a primitive component that is rich in the culture and customs of the remote history of mankind.

When an individual begins to get mentally sick, he first gives up those environmental activities without which he can most readily get along, namely his diversions. As his illness progresses he becomes less efficient at work, finally relinquishing it entirely. He is so engrossed in his symptoms that he fails to give usual consideration to everyday contacts. He steadily becomes more or less completely self-centered; he loses the attributes of adulthood and reverts to his adolescence. In this stage, he repeats the moods and ideas of his young manhood; he assumes the role of a son. People around him he treats as parents, towards whom he acts as he did or would have acted, while he was still with his parents. He is neither man nor boy, but both at once, and he finds his position in life extremely unsubstantial and uncertain.

It is commonly said that he is nervous. Perhaps he is nervous. Perhaps he is characterized by intense emotional instability with peevishness, irritability, loss of appetite and sleep, and fears of so-called insanity. He does not know which way to turn. If he goes forward towards maturity—well, he cannot, he is too firmly gripped by his dreads. He tries to hold the peace he has, as dangerous as it is, but there is something within him, some force greater than his con-

scious will power, that keeps driving him to a role of more or less complete and helpless dependence.

As the individual *regresses* emotionally, that is, as he successively falls back upon lower and lower levels of his own life, he progressively becomes beset by earlier and earlier habits of his career. All that constituted his juvenile life begins to come back to him; so, too, do the many impulses that he had kept partially hidden. As an adult in chronological age he dreads facing the experiences and urges of his childhood, particularly the deeply lying ones that no longer serve him constructively. Yet, he is at the mercy of his inner drives. He recognizes the reappearance of all the childishness in him and he tries frantically to push it back into the "past" of his mind. By this time, however, the regressive trend has gained so much momentum that he alone cannot stop it. He has been caught in the undertow and is being swept helplessly into the sea.

He is, indeed, a sick person, every bit as incapacitated as if he were suffering from some pernicious organic disease. Few things are more devastating, more demoralizing than *the death-like grip of the emotions, that kill without killing*. The patients themselves use that expression, not as a figure of speech, but as something that is as realistic to them as are the objects they see about them. The fact that the emotions cannot be seen is to the patient but a superficial academic question. Is an unseen cancer any less destructive? If this is a dramatic way of presenting the situation, it is so, only because it is so.

It is at great variance with the truth to turn away from him with the conclusion that his suffering is imaginary, particularly if by that conclusion it is meant to imply that he has "nothing the matter" with him. Such a specious decision is belied by his anguish. Save in isolated instances, tradition in medicine has grown up around "matter." The remarkable advances in *materia medica* over the past century made us so materially-minded that for years medical men overlooked the greatest single cause of human suffering, *the emotions*. In spite of the equally impressive progress in the realm of mental medicine, man still clings tenaciously to the concept that all suffering stems from material or matter as such in the

old, traditional sense. He still reluctantly accepts the inference that maybe the hopes and frustrations of his life are essentially a part of him.

Experience seems to point to the thought that man's belief in the organic origin of his miseries grows out of the age-old concept of the inviolability of his mind. Eons ago the pattern was designed which taught man that he is the image of the prevailing God of the times. Today, as in the past, man's emotional or mental beginning is based upon omnipotence. There is something miraculous about an infant. When he first begins to acquire the status of an individual he is invested with the thought of unlimited power. There is no adulation to equal that bestowed upon the first act of sitting upright, of exchanging smiles, of grasping an object, of standing erect, of taking the first toddling steps. The average infant is the center of the world. His little mind is built up to high proportions. When to that greatly boosted self-estimation there is added the belief, perhaps based upon fear, that the mind is not subject to distortion, that it is a Holy of Holies, it is not difficult to understand why people have for ages been intensely averse to any thought that the mind can, in and of itself, be adversely affected.

Everything but the very part involved has been blamed for mental deviations. It is a paradox of an extreme order. When the heart is bothered, we look first to the heart; when breathing is disordered, our attention goes directly to the lungs; when we lose our appetite, we investigate the stomach and intestines. But, when the mind is distraught, we intentionally divert our interests from it.

From bygone centuries up to the present time whole races of people have believed in one or another variation of demoniacal possession. Before the enthronement of science, and to many large groups of people even after that, illness was a reflection of the invasion of the body by evil demons. Physical ailments were attributed to "possession," until science actually looked into the body and failed to discover the trespassers. It took centuries to dislodge the notion of demons successfully from the organs of the body, yet the world is full of people who still hold that belief. To establish this point we need but glance at the concepts of many of our

rural folks who believe that illness is a kind of retribution imposed upon us, because we have not lived a clean life. In Polish Pomerania devils are held responsible for mental diseases. In Ethiopia demoniacal possession is held always to be the cause of insanity; in Mongolia "homicidal mania" is ascribed to Damchan (an evil spirit). The list of such beliefs can easily be made many times longer. They seem to gratify the erroneous doctrine that the mind is *per se* immune to disorder, but that it can be disrupted by external agencies. We still resort to all manner of magic devices to ward off illnesses occasioned by evil. Rituals, talismans, amulets, incantation, prayer, sorcery, wizardry, exorcism—all are believed to have magical influences.

Imhotep (2980 B.C.), known as "the good physician of Gods and men," set up a hospital for the care of the sick. By 1500 B.C. there were many temples equipped with hospital facilities. In 1400 B.C. Kuan Tzu in China spoke of special institutions for the care of mental patients. Science began to replace the "chief priest" of the combined temple-hospitals several centuries before Christ.

Pythagoras (580-489 B.C.) suggested that the seat of the soul was in the brain. Alcmaeon (500 B.C.) described some of the nerves of the brain. At about the same time Anaxagoras distinguished the mind from the body. Hippocrates (460-375 B.C.) taught that the brain was the center of the intellect, sensation and understanding. Aristotle (384-322 B.C.) considered the heart to be the seat of the soul. Erasistratus (330-250 B.C.) further subdivided the nerves of the brain. Studies on the anatomy of man were progressing slowly, because they had to overcome the indoctrinations of the ages before them, as well as wait for the development of scientific procedures.

We get a fair glimpse of the background which we have outgrown, when we appreciate that the doctrines of Celsus (20 B.C.-A.D. 50) influenced the medical world up to and through the eighteenth century. Sadness, he believed, was due to black bile; other moods were caused by other body disorders. But little attention was given to another cause considered great by Celsus, namely, "false images" and disordered judgment. The medical field was un-

prepared to test the validity of the last-mentioned cause. Galen (A.D. 129–199) conducted considerable research on the brain. Aurelianus (*ca.* A.D. 500) questioned the relationship of black bile to melancholia.

During the Middle Ages of medicine, extending from Galen to Vesalius (1514–1564), the medical world was almost completely under the domination of demonology, witchcraft, sorcery, astrology and what was called humoral pathology, that is, morbid phenomena due to the fluids of the body.

By recourse to astrology, scientists for a time played shy of the body as the source of illness. Blagrove was not alone when in the seventeenth century he wrote that "there is no infirmity or disease whatsoever, but in the second cause proceedeth from the influence of the afflicting planets." Saturn governed the spleen; Jupiter ruled over the lungs, liver, pulse, and semen; Mars controlled the kidneys; Venus the uterus, breasts, and genitals of the female; Mercury stood over all mental processes; the Sun ruled the brain, nerves, the entire right half of the body, but the left eye of the woman. Paracelsus (1493–1541) gave great impetus to this school of medical thought, believing, among other things, that he was able to shift diseases from the body into the earth with a magnet.

The study of the diseased body as a special branch of medicine is barely a century old, and at that, the first many years of the century were consumed in observations on corpses. Modern physical medicine is in its youth. Because it is so, in conjunction with other popular and professional beliefs, it can be appreciated that the science of the mind is still regarded askance by many.

This brief historical sketch enables us to gain an appropriate feeling for the current concept—not everywhere prevailing, as yet—that the mind is an inviolable part of the body, whereas in truth it can be immensely swayed by whims, it can be made better or worse by training and experience, and it can be driven to distraction (a pulling asunder) by its own inherent impulses. Might it not be more in keeping with the facts of evolution to understand the mind as the most recently developed acquisition of the human being? It is a relatively untried possession. May we not

better grasp the significance of reversion or regression to primitive ways of mental activity through the assumption that the mind is the latest acquisition of the human being?

We know it is a property of living things to withdraw from painful stimuli. Unicellular organisms do, and so do we. At its best, life is a batch of trials and errors, trials and successes. *We need more than a sound body to get us comfortably through life; we need a sound philosophy of living; we need to grow up emotionally, too, under favorable conditions.* It should surprise no one that mental health is every whit as much dependent upon the successful operation of our mind as ill-health is caused by faulty operation of it.

Returning now to the general consideration of "growing backward" into our lives, instead of going forward, we can see the plausibility of such a reversal of our interests. Physical organs of the body undergo *involution*. Experience shows that the mind has the same property, which it frequently exercises with relative ease. Everyone seems to accept that fact as it appears in old people, but so many fail to see the same principle at work during earlier periods of life. The elderly person begins to lose the wide interests he once had. The number of friendships begins to narrow down and all say it is "natural." He does not participate in sports as he may have been accustomed, either actively or passively. He stops traveling as much as he used to. Later, interest in his daily tasks begins to lag, culminating in his retirement. He is a retired man, one who has moved backward. Whether we like the term or not, he shows the process of mental and physical *involution*. He is confined to his home.

Depending partly upon the former strength of his mind, he may go gracefully through his last years. The regression may be evidenced only by gradual mental and physical enfeeblement. Or, he may become petulant, self-centered, childish; he may fall back upon the manners of his childhood, thence to his infancy. He may have to be bathed, fed, dressed, assisted in walking. He has regressed to the activities of an infant. This type of regression we clearly recognize as a reversion to one's childhood. We do not hesitate to tell our friends that father has grown old, feeble, childish, though we

hush up the unfortunate manifestations. And certainly we want nobody to know when the poor soul shows signs of the animalistic nature in him, when he unwittingly takes care of the functions of nature in unconventional places, and when he exposes himself and makes sexual overtures to the young people of the house. We charge all this and more, too, to the decay of the body, though when we witness similar actions in young adults, who show such decay, we attribute it to some obscure body changes or to criminal tendencies.

In his last months or years, when he can no longer move as he used to, the oldster recounts—in his delirium—the events of his early life, perhaps making business deals far beyond any that he ever negotiated in real life. His ideas become more and more expansive, until they approach the omnipotence characteristic of infancy. In his fancies he becomes all that he had ever dreamed to be, including the outdoing of Don Juan.

Thus in old age he gradually retraces his life, giving vent, *en route*, to the wishes that he barely let himself recognize when his mental faculties were intact. Shelley put the cycle of life in these words:

“The babe is at peace within the womb,
The corpse is at rest within the tomb,
We end wherein we begin.”

William Cowper wrote:

“I seem to have lived my childhood o’er again—
To have renewed the joys that once were mine.”

and Eugene Field phrased it thus:

“And as of old, my mother,
I am content to be a child.”

There is no mental law by which to determine how far back in his life an individual may go before he reaches mental equilib-

rium. Some regress but a short distance, while others revert to their deeply lying primordial selves. *Regression, however, is a common denominator for all psychiatric patients.* A few examples may help to clarify this point.

REGRESSION LEVELS

(1) Perhaps the *simplest sort of regression*, the one that does not go very far into the past, is seen in the person who cannot adapt himself or herself to married life but does not resort to illness as a way of minimizing marital difficulties. As a rule they are self-centered people, have not been able to transmute selfishness into altruism and they resent efforts on the part of the spouse to get them to share life. They strive diligently to retain their bachelorhood, to carry on their lives as they had done before marriage, and when that does not seem possible, they may live under the same roof with the mate, though the relationships are distant; it is like living in a private hotel. Or, one or the other may move away or may seek separation in the courts. Or, if both are similarly constituted in the matter of leading their own lives with a minimum of reorganization, they may continue to live together, she meeting the requirements of a good housekeeper, he making excellent provision for the maintenance of the household. To all outward appearances they are a happy couple, often characterized by their friends as ideal. They are usually courteous, well-mannered and generous with endearing terminology. Both may go through life contentedly. If children are born to them, they route their emotional lives to the children and all turns out well. In this latter situation there is no regression; it may be said that there is progression, though from the emotional point of view there is very little of it.

The spouse who gives up married life, returning to his or her own parents, takes a step backward, even though it may be a move conducive to the happiness of both. Some of these people seek assistance in the field of psychiatry and are considerably benefited by it. They either go back to their former partner or re-marry with reasonable confidence that they can merge their interests successfully with a spouse.

The so-called stigma of going to a psychiatrist is steadily losing its weight as such, particularly as it becomes known that psychiatrists treat also the emotional problems of many people who are not seriously handicapped; indeed, many psychiatrists today have an active practice among those who by no means could be called psychiatric patients in the popular sense. *The old idea of psychiatry and insanity as yoke partners is gradually being removed. Mental hygiene is as sound in its ways as is physical hygiene.*

(2) Perhaps the *next level of regression* is represented by those who (let us assume that they are married) are inwardly bothered by the conditions of marriage, but who are eager to keep the vows as inviolate as possible. Some feel that they should not have married while their parents were living, or at least until they could have separated from the parents with a minimum of disruption. Others feel that they should not have married with the satisfaction of their biological urges uppermost in their minds. Still others are disappointed because an unbridgable chasm separates what they fancied married life to be and what it actually turns out to be. They are conscience-stricken, because they are faced with the impulse to dissolve the partnership in spite of the fact that the mate is kind, considerate and loving. They know too well that they are pretending to care for the spouse, and it hurts more to know that the disguised cheating is successful. The remorse gives rise to tension, the sense of guilt mounts slowly but steadily; it is covered up with more pretenses of kindness until the overload forces the guilt into one or more organs of the body. Stealthily feelings of organic sickness supervene. Now, instead of the conscience being stricken, the heart, or stomach or some other organ is affected. *The hurt has simply been shifted from the mind to the body: it is the same injury but in a new place.*

However, in its new location, it has gained many advantages. The sense of guilt is alleviated. The husband commiserates with the wife, gives her added and closer attention. In this early transitional stage she is torn between remorse and bodily distress, both of which are later ameliorated when the physician converges his attention upon the organ of which complaint is made. He assumes that her

troubles are in the body, and, though all physical examinations are of no positive diagnostic avail, he still feels that the problem is organic. Then comes the magic of medicines (magic in instances of this kind), which for a greater or lesser period of time restores marital harmony. But it never cures the patient, because the symptoms persist, perhaps mildly and indefinitely, or until such time as circumstances unconnected with medicines bring about cure.

Seemingly unrelated conditions may favorably influence the course of the organic ailment. Social, economic, emotional circumstances may bring about such changes as may relieve the wife, in this instance, of the difficulties she experiences in marriage. Death of the parent who was dependent upon her may remove the cause of her troubles. Or, the husband's compromise which enables her to maintain close association with her parents. These and other possibilities are often contributing factors in the cure of emotionally induced physical states. They are seen not at all infrequently in the offices of physicians.

(3) *A third level of regression* is observed among those who are psychologically unequipped for marriage in virtue of their fixation upon members of their own sex. Physically they may be, usually are, normal, but they are not attracted to the other sex. When, for instance, they find themselves in a situation that ordinarily might lead to the expression of closeness, they are uneasy and indicate by behavior, if not by word, that they would like to keep the relationship on an impersonal basis. With members of their own sex, however, they can spend hours in facile conversation on all manner of topics.

When this kind of person marries, he may continue his bachelorhood without attracting any particular attention on his wife's part. In practice it often happens that way, for the reason that, perhaps without knowing it too clearly, she married him because she thought he would not bring any material changes in her ways of living. With minor and inconsequential changes both continue as they had done prior to marriage. Any fair-sized community provides a variety of adaptive possibilities for such a pair.

If one or the other of the married couple is unhappy under such

an arrangement, separation or divorce or falling sick may be the answer. One of the pair may grow up emotionally, while the other remains fixed. The unwritten terms of the courtship and marriage are then considerably altered and a realignment on some basis becomes necessary.

On occasion psychiatrists see patients, now grown up and married, whose parents had evidently been disappointed in the sex of the infant. They had pinned all their hopes on having a boy and while the girl is growing up the parents rear her in accordance with their former hopes, unmindful of the daughter's wishes. She is trained in the management of boy's toys, is praised for her mechanical and athletic activities, has her mind bent in the direction of a man's career, and usually in a nice way, she learns how to keep the other gender at a "respectable" distance. Tiding her over the period of puberty and adolescence along similar male lines, that is, as a male, may be a task of considerable moment, yet, too often the parents succeed, with disastrous results. The struggle between nature and nurture often culminates in the girl's misery, mentally or physically manifested.

Overt homosexual individuals, those whose peak of satisfactory living is achieved in physical and emotional union with another of the same sex, *ordinarily have no conflicts*, unless or until one of the partners shares his or her affections with others or leaves his or her partner for other reasons.

Then there are those people whose inner (unconscious) lives are strongly homosexual, but who try to maintain wholesome relationships with the other sex. This balance of power is extremely difficult to maintain and usually leads to peculiarities of one kind or another. The strength of the latent homosexual drive may compel the individual of this type, greatly against his better judgment, to resent members of his gender. He criticizes them unduly for some inconsequential infraction. He stands aloof from them in social gatherings. He suspects that their humor is meant to embarrass him, though he reasons that it is not so. He is in truth a very unhappy fellow, as uneasy with his own gender as with the other.

Many such latent homosexual individuals cannot keep the im-

pulses from entering their conscious mind. They are constantly being tempted to accept the proposals to become homosexual and they struggle energetically to drive the thoughts from their mind. Usually they do not succeed, except by a devious method of mental activity. They begin to disown the impulses on the basis that they are nothing more than distasteful invitations from other men (in the case of men) or women (in the case of women), whereupon antagonism to their own gender becomes sharp. Now the patient firmly believes that the conflict is between him and men. He has thus absolved himself from any culpability in the matter. He has become a paranoid patient, showing a special type of regression (see Chapter 14).

Regression is a general phenomenon that may be observed in any one of the classifications of mental disorder. A homosexual conflict may result in mild or severe irritability, with other changes in the character of the person. In this form it is said that the individual has a *character neurosis*, by which is meant *that his character traits are in effect the equivalent of formal symptoms*. Or, the homosexual trouble may take the form of delusions and hallucinations, as in the paranoid form of schizophrenia; or, of physical complaints as in *conversion hysteria*; or, of anxiety as in anxiety-states; or, of compulsions and obsessions, as in the compulsive-obsessive type of psychoneurosis. These are the major manifestations of regression to the level of juvenilism. Professionally it is known by the name *suigenderism*, standing in contrast with *altrigenderism* (of the other gender).

These concepts, representing life situations that are not at all uncommonplace and constituting the core of existence of many people, are based upon the theory of the reality of the mind. They cannot be understood in terms of organic structure, such as the idea of touch being related to the skin, or of breathing to the lungs, the pulse to the heart, seeing to the eye, etc. This whole array of psychological facts, so rich and extensive, with an almost endless number of permutations, eludes body localization. We know where to look for the origin of movements of the limbs, of blood circulation, etc., yet we have nothing even distantly suggesting proof of

the whereabouts of the tissue giving rise to that part of us with which we have greatest familiarity—the mind. We are in the unique, but by no means unhappy, situation of identifying and working with the vast results of what is called *mental activity*. It may be said that *we study and treat functions, though we do not know from what part of us they arise*.

It is a remarkable fact in a human being's life that nature herself allots a period of approximately seven years for the child to grow partly away from itself and his family and partly towards others outside of the family. The seven-year period extends from the age of five to twelve. Moreover, *in this seven-year period the boy's adjustment is largely with boys, the girl's with girls*; this is a period of *suigenderistic* growth. There is no other living being that consumes such a long time with its own sex on its way towards maturation. But, even with such a long span our society knows all too well that the child has reached only organic maturity. Realizing this, man has intervened by enacting legislation that extends the seven-year period from six to eight years more, during which extension the young man and young lady gradually emancipate themselves from their own gender and attach themselves to the other gender. It, therefore, should not occasion wonderment that, after such intensive psychological conditioning, *some individuals find it difficult or impossible to transfer their interests from their own to the other gender*. With this knowledge it is not surprising that regression or inadequate progression is as widespread as it is.

We must look back, however, to see out of what the *suigenderism* has to grow. Then, perhaps, we can appreciate why the human being has to spend at least seven years in effecting extra-self and extra-familial attachments.

If we were to summarize in one word or idea what has been said in the last several pages, it would be the concept *altruism* in its literal sense of *other, another, other people*, in contradistinction to *egoism*. Even under the most wholesome conditions the processes involved in transferring our emotions from egoism to altruism are fraught with difficulties. Benevolence, the disposition to promote happiness in others, is commonly achieved in full measure very late

in life. That is a biological or, better still, a psychobiological fact. Man consumes the greater part of his life in the development of his own happiness and society commends the citizen who is contented. Looking at it from the life history of the average individual, there is good reason for the commendation, for his happiness is largely predicated upon the integrity of his self-esteem, of his ego (ism) of infancy. Selfishness, that is, chief regard for one's own interest or happiness is a natural, normal part of our life. It appears with the first recognition of ourselves in infancy, when, fostered by the parents and others, it is more or less totally devoid of anything resembling altruism. Man's first esteem is built around himself and normally it constitutes a thick layer of protection. It is the life of the infant, the quality that leads to health and happiness. Without it the future of the child is stunted.

The period of *psychological infancy extends from birth to approximately the fifth year*. None of the periods of growth, however, is sharply delimited. Growth is a continuum, the individual passing from one phase to its next in an almost imperceptible way.

Normal progression implies the relinquishment of instinctual energies from their crude and overt, infantile manners of expression. The energies thus released are put into the service of newer ways of growing up. They are refined, so to say. The egocentricity of the infantile period gives way, in part, to juvenile forms of participation with other children, particularly with children of the same gender. This is the phase of instinctual growth known as the *suigenderistic*. In the next forward step part of the energies leave *suigenderism* in favor of *altrigenderism*, that is, the individual shares a portion of his instincts with members of the other gender. Marriage and the rearing of children completes the cycle.

Regression denotes the reversal of the foregoing steps of growth. It may start at any level of adaptation or, as is the situation with those who live to an advanced age, it may come about very gradually as the body undergoes senile deterioration.

In this backward tracing of human growth, which is the course taken by the individual who is falling ill with emotional or mental disorder, we see him relinquishing his highest or most refined forms

of adjustment (professional, social, recreational, marital, etc.) in favor of those at the next level below—suigenderistic. He may fall back upon juvenile ways of living. He may remain at that level or regress to the infantile or beyond that to the primitive. He tries to recapture the highest achievements of his life, but too frequently confusion and turmoil preclude that possibility, unless mental therapy is applied. If it is not, he may go on through the rest of his days and years a slave to his instincts.

A large number of individuals struggle against the backward trend, but find the odds against them. There is not enough energy available in their conscious will-power to prevent them from being literally dragged down into the questionable solace of infancy. For those who object to the return, nature offers a compromise, one that is poor, to be sure, but at least face-saving. This is observed when patients reluctantly, but inevitably succumb to a psychiatric illness.

As illustrations of this manner of regression, let us cite a few examples. The simplest is that the adult-child who, moving back into his family or a substitute thereof, is peevish, petulant, thick-headed, inconsiderate of the needs of others in the family. Usually he also has preposterous ideas of his own superiority and feels that others either fail to appreciate his import or willfully hamper his progress. Yet, he never makes a single move to establish the reasonableness of his claims.

When this adult-child is strongly marked with sexuality, the difficulties attendant upon regression to an infantile level are often extremely acute. When his sexuality begins to be directed upon his family, usually he is so perturbed that compromises in the form of morbid symptoms are the only solution. Some regressed adult-children kill themselves when faced with this issue. Others kill one or both parents. It seems, however, that the vast majority meet the unwholesome sexual impulses by disguising them into psychiatric symptoms.

A young man fell in love with a girl, but was too ardently in love with his mother to effect a transfer of love from the mother to the girl. His father did all he reasonably could to keep his son's

interest in the girl. Soon the son began to grow antagonistic towards father. First came verbal clashes, later fisticuffs. Mother took the boy's side. The girl was given up, but relations in the family continued strained. 'Slowly' the son began to express peculiar ideas, which became so severe that within a few months he had to give up all activities, save those few that he had around the house. Had he openly avowed determination to possess the mother at the expense of the father, he could not have done so more completely than he did through the symptoms of psychiatric illness. He was so "nervous" that he could not get up in the morning, whereupon mother not only took food to him, but actually engaged in feeding him. Often she bathed him, because he was so "weak." The total relationship was essentially no different from what it had been when he was four or five years old.

He developed the *obsession* that the gas jet in his room was open so that there was a constant stream of gas issuing from it. Another obsession had to do with the impression that the door to his room was unlocked. All night long he would go to the gas jet, test the pet cock to see whether it was closed, would sniff for escaping gas, apply a lighted match to the burner. When satisfied for the moment that gas was not escaping, he went over to the door and tested it to make sure it was locked.

This situation prevailed for months. Only his mother could nurse him. He drove his father from the room, or, as he led himself and his parents to believe, his "nervousness" drove the father from him. Like other patients with such symptoms, he never tried to peer behind his symptoms. Accordingly, he was greatly amazed when asked by the psychiatrist what would happen if gas did leak from the burner. He was pleasantly surprised to think that certainly nothing would happen to him. All during his illness he was never alarmed in the least about his own safety. Why should he have been? His fear of leaking gas was strictly psychological and, therefore, followed psychological and not physical laws. Further examination revealed that the gas would leave his room by way of the door, go up the corridor, into the father's room and asphyxiate the father. Thus, the arch rival was done away with by the son's obsessions and

compulsions. His inner, unconscious conflict secured an outlet through symptoms.

Symptoms never gratify. They only hurt. They are the penalties one pays for unwittingly having such unconscious and unconscionable impulses.

Compulsions and obsessions pyramid upon one another until the patient is buried under the towering superstructure. It is this condition that makes patients feel that life to them is actually a living death.

Some adults, and they are usually psychoneurotic, react to the role of childishness with great mental pain, while others, ordinarily psychotic, though resentful of the role at first, later may adjust themselves comfortably to it.

A young lady, inordinately attached to her father, was outwardly subservient to her mother. Since late adolescence she had been uneasy with both parents, because she realized that she acted as a little child to them. For several years she had flirted with eligible young men, but kept them at great length from her, whenever they wished to express in acts their more intimate thoughts to her. She held them as far away from her emotional self as she did from her physical self.

When she became engaged to a young man, it was obvious that she was more dependent upon her parents than she had been in years. Hardly anything took place between the young people that had not first been lengthily discussed and finally endorsed by her parents. The latter came to feel that the daughter's necessity to take all her problems to them bordered on abnormality. It reached the status of compulsion, being very little different in principle from the dependence she showed when a little girl. Furthermore, she began to develop a sense of wrongdoing, of guilt, which widened the gap between her and her fiancé as the engagement-status went on.

Then she became excessively overneat, first about her person, later about things around her. This led to a morbid dread of uncleanliness. She bathed several times a day, spending preposterously long periods in the shower room, washing and washing herself until

she developed a skin disorder. When she was not bathing, she was washing her clothes. The compulsion became unbearable, yet she was never able to reach a stage of cleanliness that satisfied her. Of course, *she scrubbed everything but the unclean part—her mind*, and, therefore, she could never become clean where there was a need for cleanliness.

The irresistible urge to clean kept spreading from her to her parents, to her fiancé, thence to her room and finally to all rooms of the house. When first seen by the psychiatrist she was at home scrubbing the rooms feverishly; so were her mother and father, both of whom had already spent days on end scrubbing and scrubbing. When her fiancé called he, too, was set to scrubbing.

This is not an exaggerated account. The entire household revolved around the daughter's fear of dirt. She compelled her father to wear newly cleaned gloves while reading his newspaper, or opening the door, or removing his eyeglasses. Mother was similarly gloved for all her duties. All windows in the house were sealed against dirt from without.

The daughter enslaved her parents to the degree of extreme and abject obedience to her, yet, she believed herself totally dependent upon them. It was evident that the three had never before been so completely of one mind. To be sure, each was frantically harassed. Again we see the price one pays for a neurosis or rather for regression to one's childhood. There is nothing more humiliating, more tempestuous, more disorganizing to whole families than an emotional sickness. It is not accidental that the pains are extended to all susceptible members of the family. It is commonplace for the patient to give lip service to the distress she is causing the ones dearest to her. But, the patient is no more to be blamed for an emotional sickness than she would be for appendicitis or gall-bladder disease or any other physical disorder. She is in greater turmoil than those whom she makes miserable. She is not a child by choice, but by unconscious coercion.

That this particular patient was a child was all too clear from the many examples that could be cited. At the peak of her illness her mother bathed her, dressed and undressed her, helped her to eat

and had to be with her constantly. It is, of course, unnecessary to mention that physically she was a strong girl. In her illness, she exerted herself far beyond her usual daily output of energy.

Because we are concentrating upon the exemplification of a single feature in psychiatry, namely, regression, we are skipping many other interesting aspects of patients. They will be taken up in later chapters. For present purposes it is emphasized that *psychiatry is a study of regressive phenomena* and the last several examples have referred to the recession to the childish phase of selfishness, which to the psychiatrist is known as narcissism (from Narcissus who was told that he would have a long life, provided he never looked upon his own features). For purposes of simplicity and clarification, but not at all strictly in accordance with laws of growth, it might be stated that, from the emotional point of view, the period of infancy is roughly divided into two major portions. Since we are going backwards in the life of the individual the half of infancy, the narcissistic, the one just described and which we encounter first in our retrograde movement is *actually the later, second half* of infancy. It is built around the child's concept of its mental self, its accomplishments, its movements, speech, early learning habits, manners, etc. To be sure these faculties *begin to develop in the earlier, first half of infancy, but they achieve great significance in the second half*—the one first struck in the process of regression.

Now, when we turn our attention to the first half of infancy covering the period from birth until about the age of $2\frac{1}{2}$ years, we know that the infant enters the world essentially as a vegetative unit. The mind is embryonic in point of environmental stimuli. The first manifestations of life are best understood as physical phenomena. While still in the mother, the human being shows rudimentary body reflexes. The spinal reflex may be ascertained at the second month of life in the womb; mouth movements—at the third month; reflexes in the head, arms, and legs—at the fourth, fifth, and sixth months. According to many observers the vital reflexes necessary for post-natal life are well advanced by the seventh month. There is evidence of pre-birth sensitivity to light, sound,

temperature, and to change in position. These are but a few of the activities of the embryo, but they serve to emphasize the fact that the body becomes energized so as to produce movements which are perfectly visible externally while the baby is still in the womb.

The sense organs undergo rapid advancement after birth. Here we are merely calling attention to the organic growth of the infant. Perhaps the earliest imprints the mind of the child receives from without have to do with hearing, touch, sight, smell, and taste. Language is a process of slow development starting with the cry, in which within the first few weeks there can be distinguished differentiation for discomfort, cold, hunger. The child can vocalize pleasure at three months, eagerness at five, can say, "Papa, mama" at nine months or a little later. It is generally agreed that the child's speech is largely egocentric during the first six or seven years of life.

The egocentricity, moreover, is of a special kind, since it is highly infiltrated with the child's concepts of itself as a physical being. This is especially true during the first half of infancy. It might be said that the child's mind is body-minded, and is made so by the necessities of that age. It is entirely natural and normal for the mother to stimulate the baby's mouth, gastro-intestinal tract, eyes, ears, skin, etc., and to train these body parts to appropriate responses. Even under the best of conditions this is a long period of training. It leaves impressions that are deeply engraved in the child's mind, impressions that to a greater or lesser extent condition it for the rest of its life.

As influenced from external sources, *the prime layer of the mind is made up of images of one's body*. There is, also, a second implanting of equal importance. *The child's first emotions are heavily invested in its body-minded mind*. The investment, furthermore, is fixed by the emotion of the mother and/or the father, or by parental surrogates. The child-parent relationship gains intense union during this period. Later we shall see the many variations of mature adjustment that refer back to this age of child-parent relationship, dependent as it is upon the psychology of the parent or parents

towards the child's physical manifestations and also upon the impressionability of the child's mind.

For the moment, let us take a single example of the influence of body-mindedness upon an individual's course of life. A thirty-nine-year-old man lives for his gastro-intestinal tract; he knows every ounce of food he eats, knows whether it is cooked properly for him, what its constituents are, when he last had this or that foodstuff, how it affected him; he remembers with great clarity the effects of a certain kind of apple-pie that he ate in San Francisco fourteen years ago; he can recite an endless number of similar events. His memory is equally good for activity at the other end of the alimentary tract, for quantity, color, consistency, frequency, odor, etc.

He is very keen to all body sensations, such as itches, soreness, heaviness in the extremities, tiredness of the eyes—indeed, he makes a mountain out of every mole-hill; *natural body-sensations are viewed by him as symptoms of irregular gastro-intestinal activity.* He is the picture of good health and, for years, repeated physical examinations have verified the soundness of his physique.

He is a bachelor, though he has had an occasional woman friend, especially since the death of his mother, when he was 28 years old. The few women friends were of the psychological make-up that complemented his: they were mother-nurses to him, made frequent inquiries regarding his gastro-intestinal activities and the associated body-feelings, advised him as regards food, kept him informed on new medicines. They substituted other remedies for his daily dose of Epsom salts, seconded by semi-weekly enemas. In plain truth these associations with women were nothing else than "gastro-intestinal friendships."

Two of the women made veiled references to the possibility of marriage, whereupon he found reason suitable to him to withdraw from them. Upon returning home from work each day he had so many body rituals to perform that it deeply concerned him to know that, with another person around, he could never do the things he had to do and still go to bed for the necessary hours of sleep. Besides, there was the additional embarrassment of nightly preparing his shoes against athlete's foot, which was always a possibility be-

cause, as he guessed, the skin suffers when the gastro-intestinal tract does not function properly.

Save for the entry-clerk's menial type of work in which he engaged, merely because he had to earn a living, his life was empty, except, of course, for interest in the gastro-intestinal tract.

His mother, too, was an inveterate hypochondriac; and it was the immediate cause of his father separating from the mother, when the patient was a few months old. This left her free to exploit her peculiar notions of bodily health and disease upon the boy—a situation kept up until she died. The gastro-intestinal tract in particular was overloaded with mother's emotions, to which were added those of the son. That was the Gordian knot into which they tied themselves. It made them forego recreation, study, play, work, sociability. In it were carefully concealed all the hopes and frustrations of their lives, their philosophy of living.

This is not the recital of a rare form of living. The general principle laid down, that of perpetuating into maturity the training imposed in infancy, is not uncommon to many people, though it may not be as curtailing to general activities as it was in this instance. There are all grades of training and experience, but there are all grades of responses: thus we find hypochondriacal parents who mold the child's mind to their psychology, but the cast does not set permanently.

The fact is, however, and this is the central point in our present discussion, that *the disciplines of infancy make a deep impression upon the mind of the infant, an impression that (1) may be shut out in later life, (2) may be a controlling factor throughout life, or (3) may reappear when the events of later life are too difficult for the individual to withstand.*

Life is a series of trials and errors, trials and successes. We readily concede this in almost all of our activities. When a child finds out that he is awkward physically, he may try energetically to overcome the difficulty. He applies for a position on the basketball team in school, but it turns out he is not as agile as other competitors and he tires more easily. He competes with the kids in the neighborhood for a place on the baseball team, but does not make it. Over

the succeeding years he keeps failing athletically and finally abandons physical competition.

In the meantime he realizes that he stands up well in intellectual competition. He often gets on the school honor roll, is made a member of the student council, the debating club and other academic organizations. He gives up competitive athletics in favor of building up his intellectual capacities. The latter may serve him excellently, especially if his emotional life is well taken care of. *There is nothing more nourishingly wholesome to intellectual progress than stable emotions, nothing more impoverishing than emotional turmoil.* Feelings can further the efficiency of the individual with an average intelligence quotient, while they can enormously reduce that of the intellectual giant. The patient who is plagued with distorted emotions is often rendered "feeble-minded" for the duration of his troubles. Fortunately intellectual achievement is restored when the emotional turmoil has been removed.

If he is unfortunate enough to have both a poorly co-ordinating physical system and an inadequate degree of intellectual capacity, he may have to fall back upon his "disposition" as his forte for adjustment. He then charges his emotional attributes with the responsibility for carrying him through life.

It may be said that human beings operate on the basis of the *check and balance system, consisting of three departments—(a) the physical, (b) the intellectual and (c) the emotional. When there is harmony in the respective working of each of the three as well as in the joint working of all the three, the individual is sound and normal.* A disabling fault in one of the three creates an imbalance that often appreciably reduces the efficiency of the individual.

Each or both of the remaining two can be used to help the third. We see that happening every day. A sound disposition and a good physique may easily mask either an originally defective intelligence or a good intelligence that is not being put to optimum service. Likewise personal and public esteem may be gained through physical and intellectual fitness in an individual who is emotionally immature. And, perhaps, best understood by all is the value of emo-

tional and intellectual soundness as counterbalancer for physical inadequacy.

However, these three properties have different strengths in and of themselves, strengths that are intended for special use. The physique, for example, cannot reasonably solve an intellectual question, although it is often called upon to do so. One of the best proofs of this is the ineffectualness of war as a solution for social, economic, or ideological differences among nations, or fisticuffs, among individuals, to settle an "argument."

These, and similar observations, are the veriest platitudes yet they are the basic elements by which we live. Too often it is said that psychiatrists deal with the exotic, with things that are foreign to the average individual. Nothing could be further from the truth, for in actual practice the tools with which the psychiatrist works are the emotional, intellectual, and physical experiences through which the individual himself has passed, tools that, because they were designed by him or in his presence, are readily understood. They are the common denominators of life and of living.

The three requisites of living have more or less in common another characteristic that is of surpassing importance. It is a well-recognized fact that, as a rule, all organs of the body are not of equally good strength. In most individuals there is some weak or relatively weak system. In some it is the circulatory apparatus, in others the respiratory, or the alimentary, or the blood-forming, or the eliminative, etc. Often one or more of these systems peters out early, sometimes owing to poor original equipment, sometimes to excessive use, sometimes to poor management, sometimes to accidental external causes. Whatever the circumstance, the system falls into a state of lessened efficiency, often compelling the individual to restrict the use of the system to a minimum not unlike that prevailing in his very early life.

Physical regression is inevitable. It is so much a part of our lives that we take it for granted. Indeed, *we do not like to think of illness as a regression*; so we simply call it by the name that the physician gives it. We are much less unhappy with a broken bone caused

by a fall than we are with one due to faulty biochemistry. Except for bacteria and other foreign organisms and for accidents, the greatest single cause for physical ailments derives from the tissues of the body in virtue of their own weaknesses. The doctrine of physical regression is too well-known to all of us to need calling attention to it.

Insofar as our present knowledge extends we believe that intellectual capacity is a fixed unit, that is, it remains basically the same throughout the health of the individual. It might be likened to a container that can hold so and so much; it does not change in size in the same individual, but the quality and quantity of what is in it may vary appreciably. As to what it actually holds, there may be considerable fluctuation in a given individual from time to time, that is, there are periods of progression and of regression. Which of the latter two is the more widespread in any large group of average individuals has not yet been ascertained by careful research. It may or may not shed some light upon the question to know that in 1940 in the State of New York, where educational facilities are widely available, forty per cent of the population of the age of 25 or older had been graduated from the eighth grade; thirteen per cent finished high school; five and one-half per cent completed a college course. Maybe this view places too high a premium on formal learning under tutelage. Whether it does or not, it is a fact that, in the intellectual sphere, regression is a likely contingency. Moreover, it is easily incited by organic and emotional disorganization.

Regression is a susceptibility of living matter, one that too frequently sets in prematurely. Regression can be as precocious as progression, that is, one individual may revert to a former state with as much ease as another person may advance to newer conditions. It was this observation that led psychiatrists about a century ago to coin the term *dementia praecox*, which literally means premature dementia. It was recognized that, though physically and intellectually sound, the sufferers from this disorder did not reach maturity in thought, feeling, or action; they either remained childish in their life reactions or they fell back upon childishness after a relatively brief pause in maturity.

LEVELS OF EMOTIONAL GROWTH (in regression)

For the moment let us briefly review the levels of emotional growth as they have been merely touched upon thus far in this chapter.

(1) Leaving out senescence, the topmost level is one at which the individual is most highly socialized. He spreads his interests in many directions—professional, social, marital, recreational, religious, etc. Altruism prevails over egoism. He is at ease with himself and with others. It may be called the *altrigenderistic* phase of living.

(2) Next below it is the level characterized by prevailing associations with members of one's own gender (*suigenderistic*), at which stage there may be just as much altruism as there may be in the top stratum; there may be more or less, but the important point of consideration is gender.

(3) The next lower level is the *egoistic*, known also as the *narcissistic*, so termed, because in this period of growth the individual's emotions or interests are largely confined to himself, particularly to his mental self.

(4) The next or *fourth* level counting from the top is distinguished by the dominance, in the child's mind, of concepts of himself as a physical entity. This stage represents the earliest expression of primary narcissism; it could be called the *physiogenic* or *somatogenic* phase of mental development; both terms mean "arising in or born of the physique."

(5) Experience shows that there is a still lower level, one at which the individual lives with a wealth of ideas and emotions more or less totally unconnected with anything he had ever experienced since birth.

The development of this field of observation goes back many centuries, but it was opened up for more complete investigation with the introduction of Freudian psychology (psychoanalysis). Freud's earlier researches led him to investigate minutely the *personal* experiences constituting the individual's life and to evaluate them in terms of the patient's symptoms. He was able to see a relationship between past events and present symptoms. His searching

carried him back into the life of the patient, as far back as the patient could remember. It may be said in general that the type of patients whom Freud studied fell under the psychoneurotic classification, more particularly those whose illness did not completely incapacitate them. They were able to remain in the community with a capacity, restricted to be sure, for maintaining social, recreational and vocational contacts. Their problems were usually understandable and treatable on the basis of their known personal experiences.

While Freudian concepts were in the process of elaboration, investigators in another field of mental disorders began to apply them. Jung, for example, tested them on patients with full-blown dementia praecox. At the peak of their illness these patients are as a rule completely withdrawn from all the realities they ever encountered. This is particularly true of one subdivision of this group (see *hebephrenia* in Chapter 14). Jung concluded that in those days Freud's ontogenetic researches, relating to the history of individual development as distinguished from phylogenetic researches pertaining to genealogical development, failed to throw light upon an extensive and highly wrought group of ideas by which these patients sustain themselves in fantasy. There was found a richness of mental activity, inexplicable in terms of personal development, incomprehensible from the standpoint of personal experiences in the life of the individual.

Jung and subsequently many others tested this wealth of alien ideas against observations related to the beliefs of primitive man. There was found a striking parallelism between the two, the dementia praecox patient often expressing beliefs exactly similar to those of primordial man. The patients themselves, entirely unschooled in ethnological matters of the distant past, were completely unable to explain their beliefs.

Here we think it necessary to give a mere summary of some of the most prominent phenomena relating to man's primitive unconscious life. As the account proceeds, the reader will notice here and there certain clear resemblances between the nature of dreams and that of the advanced dementia praecox thinking. The laws of dream language are similar to those of primordial thinking. Back

in 1829 Carus said: "Morbid mental conditions presenting themselves as a reflection of a disease of the organism are rendered more comprehensible, if we look upon them as the reappearance of a peculiar form of life which is normal for a lower level of organic development." Nietzsche referred to "archaic fragments of primitive life which persist in dreams," and Freud explained that "dreams preserve for us an example of the manner in which the primitive mental apparatus worked, a mode that has now been abandoned as useless."

Primitive language was extensively developed in terms of body movements. Among advanced dementia praecox patients "bizarre" movements are common. For example, some patients repetitiously produce a rotatory movement of the hand over the abdomen, explaining that they are opening a window in the interest of fertility, a belief not uncommon among primitives.

In the delusion that what happens to the person's own body influences the universe, the dementia praecox patient sways to and fro in order to keep the universe moving or he stands immobile to stop action in the universe. This magical belief is associated with the belief in cosmic identification, that the individual is the cosmos and the cosmos is he. A correlative notion is that of omnipotence, well-developed both in the primitive and the patient.

Among these patients one frequently encounters the doctrine of reincarnation in the thought that birth represents the reappearance of a number of individuals who had previously existed. With this belief is interlocked the thought that the patient has always existed and will always exist.

Magical primitive transformations of the personality are common in the patient. He often repeats the ceremony of initiation, in which he "dies" and is resurrected a mature man. This is based on the primitive notion that the child does not reach manhood spontaneously, but can achieve it only through magical rituals. The transition is a rebirth, in the process of which there is mystical reunion with the mother. In some primitive tribes and patients there is the belief that manhood is gained through a going once more through an existence within the mother's womb.

During the process of regression the dementia praecox patient reverses the law of language development, which says in effect that thought and language change from feeling, concreteness and perception to reasoning, differentiation and abstraction. It is remarkable to see how closely the language and thought of the dementia praecox individual resemble those of primitive peoples.

To realize fully the importance of the doctrine of regression is one of the cardinal prerequisites in understanding the individual who is beset with emotional problems. Recessive phenomena may be relatively scant and mild and may arise from the more or less immediate past of the individual, or, as in extreme instances, they may be external manifestations of the phylogenetic, the primitive, i.e., the deepest layer of the human mind. When emotional distress comes upon us there is a live struggle between the past and the present, between the forces of our inner, unconscious mind and those of our overt mind. Often, as in the psychoneuroses, the forces of the past can be overcome in favor of the present ones; this is true also during the very early stages of the psychoses, or better still before abnormal symptoms have set in. The problem of treatment becomes difficult in proportion to the strength of the stranglehold which elements of the past have on the present.

Troublesome Character Traits

In the foregoing chapters attention was converged upon the emotions particularly as they coursed through body organs, affecting the latter to a greater or lesser extent in proportion to the degree of tension induced in the organs. The general idea was gathered that *a person's emotions are its very mobile units capable of reaching and gaining access into all organs of the body*. Moreover, they are extremely rich in point of experiences, as from birth to the grave they partake of all the experiences of the individual's life. Another of their characteristics spoken of in the preceding pages is that they stem from a part of us that is completely inaccessible to us, save through special technical procedures. Because of the place of their origin we have no more control over them than we have over the activity of the heart or liver or stomach. However, over the years the normal person has learned how best to make provision for them, so that when they rise to consciousness they can be piloted into an appropriate channel of environmental activity or be held in quiet abeyance until a proper occasion arises. *For good living it is just as essential to know what is best for the emotions as it is to realize what foods are suitable for us, what measure of exercise the heart can comfortably sustain, what exercise is within the limits of tolerance of our muscles, what lighting is best for our eyes, what kind of sounds for our ears, what degrees of heat and cold for the skin. Emotions are no less susceptible to variations of stimuli than are the tissues of our body.*

Emotions are real and vital. They need proper care and supervision and nourishment. We spend money on clothes, cosmetics, recreations, food, education, housing, traveling, etc., but we do

not spend a nickel to improve the very part of us that really counts most—ourselves, or our *selves*. When we go to our physician with an emotional upset, we hide that aspect from him, telling him only the body effects caused by the moods. We are not honest with the physician, least of all with ourselves. Even when his extensive examinations reveal no organic cause, even when he says, "There is nothing wrong with you," we still say nothing about the great unrest we have suffered since we lost a beloved one; we say nothing about the accompanying sleeplessness, loss of appetite, feeling of fatigue, of dire depression which we deeply sense to be the result of loss of the loved one. We plot to defeat ourselves.

VEHICLES FOR EMOTIONS

Emotions have three major vehicles through which they can be expressed. (a) *The first is the tissue of the body* in the sense that the emotions which we dare not let ourselves be aware of may be diverted into organs of the body, clogging them to the point that the feelings sent back to the mind from the organs in question are interpreted as manifestations of primary organic disease.

(b) *The second major vehicle of emotional expression is the mind*, that vast accumulation of ideas, experiences, and instincts covering our racial as well as our personal past. Just where the mind is, is an academic question of transcendent importance, but that it exists as a powerful influence in our lives is unquestionable.

(c) *The third major vehicle of emotional expression is the intellect.* This is dealt with at some length in Chapter 19.

From the first year of life onward the child begins to amass experiences that give special cast and meaning to it as a personality. In the very beginning it has energy, devoid of external connections, but affiliated with a variety of primitive drives or impulses, called *instincts*. These are necessary for life, but they must undergo considerable modification, because in their crude form they are at variance with the culture in which the child is destined to grow.

In the first instance *these instinctive impulses*, with their centuries and centuries of growth in the organs of the body, are so highly conditioned to growth in tissue that when put in a new

medium they must be cultivated with great care. This is an extremely urgent and practical fact. It is not a theory. The babe is there; it is a living organism; it has likes and dislikes; it has needs. All of these are more or less exclusively ingrained in the body. Because it cannot go through life as a vegetative and physical unit, many of its inner drives must seek a new medium through which they can reach the environment. It cannot be sufficiently often repeated that *this transition of emotions takes place in a predetermined way along old established pathways.* We have already seen the emotions, first, in the body alone, second, in the body and mind, as body-mindedness, and now we are about to see them move over into that part of the mind in which ideas and experience are stored, into that sector of the mind to which the name *personality* is given.

Personality is the aggregate of traits constituting character. It is character and it is just as definite, as important, as necessary to life as is any organ of the body. It is something which, from the very beginning, is the result of the interaction of our own mental energies modified by those of others. When we look upon the character of an individual from the bird's-eye point of view, the first thing we notice is that the energies with which character traits are endowed come from the tissues of the body. We may say that *the energy that we call emotions is body-energy that has gone over into the service of a newly growing unit, the personality or character.* Then we observe that the energy in the form of emotions has a very distinctive cast to it, in that it is very highly colored by the emotions of the parents. Indeed, *at this early stage* in the development of the child's character traits, his emotions, like an electric wire, are so thickly insulated by parental disciplines that *the child seems to be but the product of the parents.*

As we see his development through later childhood we notice that parental insulation slowly gives way to that of other adults—teachers, relatives, and less personal adults, as well as children of his own age. Parental protection is still there, but it is not so complete as it was earlier. In fact, in spots, it has so thinned down that we can see that the child itself, its own inner impulses, are beginning to show. Looking further on we detect more and more of the

child and of others (not the parents), until, towards the end of adolescence and into maturity, we see more of the child than we do of others. Then it joins with another (as in marriage) and there is sharing of the protective covering. Still further along, when children are added to the marriage, is the shielding provided by the children, which is carried along until the core of the adult gradually disappears.

GROUPS OF THOUGHT IN CHILD'S MIND

(a) It has already been said that the *first group of thoughts in the child's mind, those coming from without, are built around itself as a physical entity*. These thoughts are not of the body's own making, but are definitely those of its parents, usually of the mother. Through her the child learns a code of behavior relating to body care and body use. This code is harped upon again and again, until it becomes *second nature*. Eventually it recedes into the unconscious part of the mind, forming there the first part of the inner conscience, known in psychoanalysis as the *super-ego*. Later, as we proceed to discuss various types of family situations, we shall see that the *super-ego* is different for each individual, depending upon the influences of those who indoctrinate the child and upon the child's susceptibility to the indoctrination.

(b) *The second aggregation of thoughts in the child's mind is more definitely related to the development of character traits that are relatively free from elements of the physique, though they are the outgrowths of them*. The job of setting up this new code of behavior is first of all that of the parents and, therefore, it is almost exclusively made up of their beliefs and attitudes, modified, as the individual case might be, by whatever outside sources of information the child may acquire. Into this sphere of mental life are inculcated such concepts as leniency, initiative, punctuality, politeness, honesty, self-esteem, affection, consideration, application, courage, practicalness, etc. It is obvious that their intensity varies in proportion to the vigor or weakness with which the parents implant the concepts, as well as upon the soil in which they are implanted.

Whatever the constitution of this code of behavior may be for a given child, during the rest of its life this code is bound to be more influential than any other supplementary code that may be superimposed. Through constant repetition *the code of moral behavior, combined with that of physical behavior, becomes second nature, taking the name "inner conscience" or "super-ego."* As the child grows older the super-ego draws further and further away from conscious control, acquiring more or less autonomous action. It is thus seen also that the inner conscience now occupies an intermediate position between the underlying instincts and the overlying conscious drives.

LATER FATE OF PARENT-INCULCATED CODE

(a) As the child grows older it may adopt rather literally the code of the parents; or, it may resent some or all of their disciplines and take an opposite course in life. Whatever it finally develops or accepts as its conscious guides may or may not lead the child along comfortably. The child may waver in its choice, sometimes subordinating its conscious wishes to the control of its super-ego, while at other times it is obedient only to its conscious self. This is true of the person who is never certain of the moves he makes; he suffers from indecision or at least insecurity. He can never look forward with any degree of certainty to reacting alike in two identical situations.

(b) Again, there is also the person in whom the inner conscience or super-ego is so strong that he cannot circumvent its dominance. He is the type who lives by "hunches"; something *in him* tells him to take this or that course. He may come to believe that the "something" is definitely of his own making or he may acknowledge that it is a product of his early training. Whatever conscious explanation he gives to himself, more often than not he realizes the weakness of his (conscious) personality.

(c) A third possibility lies in the fact that the individual may intensely resent the control coming from within himself. He struggles against the disciplines inculcated in his youth, often by assuming an exactly opposite course, but it consumes so much of

his energy to hold his consciously adopted role that he is usually in a state of uneasiness.

The foregoing are but samples of conduct indicating that, after a period of apprenticeship in the organs of the body, some of the mental energies are transferred to the developing character traits making up the personality.

The practical value of this information comes from the fact that turmoil of the emotions may manifest itself almost exclusively in the realm of the personality, as a conflict in the form of character traits. A person may be intolerably severe in his relations with others. He may do what he believes to be legally right, though others may feel that he is morally wrong. Severity is a character trait that can have the strength of a morbid symptom when abused. Meticulosity, punctuality, honesty, correctness, and a host of other traits, may be expressed in such extreme forms as to be the equivalents of abnormality. The emotional trouble may be so severe as to constitute a special kind of *neurosis*, to which the name *character neurosis* has been given. Today only a small fraction of the population with this disorder seek treatment in the medical field for it, although very often it is the precursor and thereby the danger-signal of the more formal mental disorders.

Psychotherapy is applied to this group of emotional disturbances more profitably than to any other group. Moreover, to get treatment during the period of character disorder saves far more time, money and distress than to wait until the misery has overflowed like a twin of organic disease into the body and into such most commonly occurring symptoms as fears, compulsions, obsessions, delusions, etc.

A twenty-nine-year-old man was inordinately meticulous with respect to almost all things that he did. He had had this disposition since early boyhood, when he was extremely careful about the cleanliness of his body, clothes, and mind. His mother regarded herself as the paragon of all that was correct and she exerted herself unsparingly in bringing her son up to the same peak of perfection. She had married to reform a slovenly fiancé, who gave himself over completely to intellectual idealism, but in her self-appointed task

of changing her husband she was as ineffectual as she later turned out to be in training her son.

In accordance with mother's insistence the son was everything that a rigorous mother could hope him to be. Both were as one in their aspiration for the finer sides of life. Play and diversions, they regarded not exactly as sins, but withal as wasteful and earthy. It seemed that they patterned their lives after Emerson, when he said that "appetite shows to the finer souls as a disease." Son stood at the head of his class at graduation from high school. He finished college *magna cum laude*, later completing a professional course with equally high honors.

When he was ready to put his learning to practice, he was abruptly faced with the fact that for some reason which neither he nor his mother could understand, he seemed lost. Every prospective client found reasons for withdrawing his case from the patient almost before he had finished bearing about it. Both mother and son discounted such patronage on the basis that the clients were ignorant and could not grasp the issues involved. Mother and son were totally blind to their shortcoming, namely that they tried to solve all problems by being letter-perfect. The human side of the profession was given no thought at all by them, no more than they had given to other departments of living. Life to them was a classroom in which pursuit of scholastic achievement was the sole incentive. Educational accuracy was their goal.

Consequently when son left the classroom behind him to apply his learning in return for a fee, he was as inept as anyone could be who saw life only as an intellectual exercise.

It was pathetic to hear how futilely he met the human elements of living, for they were entirely foreign to him. Whatever judgments he had formed were almost exclusively about intellectual matters. It seemed unkind to think of him as an idiot-savant, which he was not according to formal definition, but he had been so carefully shielded from human qualities that one could not help thinking of the term.

From early childhood on, his associates were selected by his mother on the basis of scholarship, and, at twenty-nine, he was as solicitous

as ever towards the friends of her choosing. Since coming into physical maturity, he had had a girl friend now and then, one carefully selected by the mother with an eye to erudition and breadth of culture.

However, he was not unhappy until the series of shocks which he began to receive from what others would have regarded as commonplace personal differences. Up to that time he was a genial, good-natured fellow, entertaining with his repertory of intellectual humor.

He solved the question of inadequate practice in his profession by working in the office of a successful man. In this capacity his duties were confined almost entirely to books. He was making good headway, from his point of view, until "for some reason or another," as his mother expressed it, he lost the power to concentrate on his work. He began to stay long in bed, retiring early and getting up late. After a time he could not go to work at all and, greatly to the mother's amazement, he spent most of the day reading "cheap novels" and listening to radio romances. To get him away from such "trash" she took him out for long walks, while at home she read to him on matters of his profession.

Nor did he realize why he could not continue with his career. He surveyed himself "from head to foot," as he put it, but did not feel sick anywhere. Indeed, within the preceding few months he had been exercising at home to strengthen his muscles and to give him some color. His unaccountable irritability was believed by both mother and son to come from his lack of concentration.

What actually came to upset him was a girl in the office. For the first several months while there, he looked upon her as a part of the intellectual world in which he lived and she, being similarly minded, returned learning for learning. There were evenings when both had to stay in the office to complete an assignment, which they did letter-perfect, but which they did not do indefinitely. Eventually he began to view her as a human being and asked questions about her. She, too, learned a little about him. When they held hands, he lost intellectual and gained emotional concentration.

This is an old, stale story, as trite as can be, yet that did not make it at all unimportant to him. On the contrary, it was the turning point in his life; it should have come to him some fifteen years before, for then it did not have the great overload of learning that the subsequent years brought.

It was tragic, his mother explained, to witness the sapping of such a brilliant mind. She confided to the psychiatrist that since her husband's untimely death, when her son was twelve years old, the two had been inseparable. She was as much a part of him as he was of her. To her his was a clean and noble life, devoted to the finer things, devoid of anything coarse and crude. He must be restored, he must not go on like this. She was frantic. Make him read, make him study, she pleaded. She overlooked the fact that his concentration on romantic literature was extremely good. In her efforts to cure him, she confessed almost in a whisper for she felt it undignified, they had read novels together for the past several weeks—"not always nice ones, either"—one right after the other.

She could not see, for she did not dare, that her relationship with her son had dropped from the lofty impersonal, intellectual level to commonness, as she expressed it. She merely described the broad discrepancy between the two, without grasping the meaning behind the change. The two pictures were in such strong contrast. In the one were mother and son, alone, reading and discussing heavy, legal tomes. With an air of great satisfaction they put their books aside in the late evening, with the knowledge that the case under study was amply prepared. In the other picture mother was affecting a smile, but it was a restless grimace, embarrassing, halting, perhaps, bewildering. They alternated reading an intimate love story. In the first picture scholarship was the keynote; in the second, love and emotions.

Both mother and son saw only what they "wanted" to see of the great change in him. But, there is another force in us that really knows the truth. It resides in the unconscious. In this instance it warned mother and son that they should not go on with their love stories. It did not put it into words, but the very fact that they sought psychiatric advice was a subtle way of letting them know

that the love-story relationship had already gone farther than it should.

During psychotherapy the facts of their lives were slowly bared and pieced together. Each realized, at first with great reluctance, the inner and outer forces that in effect made them one. With considerable clarity they came to understand that each had stretched the intellectual pursuits to the breaking point and that the human nature in them, eager for freedom after so long an imprisonment, was beginning to take the place of the refined, impersonal, and studious alliance.

Hundreds of other circumstances of their lives were fitted into the mosaic. It became clear that both son and mother had ceased growing emotionally when father died. Son was then twelve years old. Thereafter she was mother to her twelve-year-old son, a scholarly, not a human mother. And he was a scholarly son.

It is gratifying to report that in both mother and son the outcome of treatment was entirely favorable. Both grew up emotionally to their chronological age.

Each had had a *character neurosis*, a special, though not an uncommon one, which might be designated as a scholarship neurosis.

There are several other aggregates of personality traits that amount to a neurotic way of living. We are not of the opinion that everybody must be treated psychiatrically, not at all. So long as an individual, no matter what his personality traits, gets along well with himself and others, so long as he does not too frequently become unreasonably perturbed, there is no need for treatment. However, there are many people who are almost always under tension: they have no formal symptoms, such as fears or obsessions or mental stomachs, yet, they live in discord. The high-power salesman may or may not succumb to his perpetual drive, and the meek and submissive individual may not chafe under subordination: some people are contented with a martyr-like course of living. The cardinal issue has to do with personal and interpersonal harmony.

In some individuals the desire to make their psychology conform with their physique often leads to painful conflict and maladaptation. A woman of thirty was brought up by a mother who was

keenly disappointed, because she, the mother, was not a male. Physically female, psychologically male, the mother was extremely jealous of men, because they were men. The mother married, because she was challenged and was aggressive enough to take up the dare to prove her superiority. She hated the role of femaleness into which she had been placed by pregnancy, but there were more deeply lying reasons why she let the pregnancy go on to full term. She wanted a boy, for then she could grow up with him as a boy; she could be a boy with him.

The patient's father was promptly relegated to a passive role by his wife, and became a sort of hired help, bossed around by her. He took orders from her, never offered a point of view different from hers and, to all appearances, accepted the role into which he had been put. Indeed, he made it even more realistic when, as the years went by, he established an enviable reputation in embroidery, a form of work to which he devoted the better part of his time.

It was quite agreeable to his wife that he should be emasculated by her; in him she found an outlet for her hostility to men and he was a willing butt for her detestation. If, before their marriage, they did not know clearly why they were drawn to each other, the reason became evident with the years: she needed a man to punish; he needed to be punished.

Marriage is not as accidental as it is commonly supposed to be. What has been known for some time now is that the parties to the contract are our "inner" selves, our unconscious impulses, which often drive us into situations to which we are consciously averse. Especially among neurotic individuals, it is not at all uncommon to marry in spite of strong opposition from the conscious sphere. This bilateral arrangement accounts for the common observation that certain married couples live together for years, though they violently oppose each other all the time, and just as violently oppose any suggestion that they separate. It is almost axiomatic that it is dangerous to the would-be peacemaker to try to stop husband and wife from tearing each other to pieces, because they are at one with each other in the depths of their heart, so to speak. The overt fight is just a superficial spat.

In this case, much to the chagrin and hatred of the patient's mother, her baby was a girl. During the succeeding years, the mother was continuously hostile to her daughter. Here was another instance of an unloved child, of one who was browbeaten, because she was not a boy. Had she been a boy, it is doubtful whether she would have fared any better, because the primary fault lay in the mother, not the child. The mother was latently homosexual. As a defense against her homosexuality, she was resentful, antagonistic, disagreeable. She focused her animosity almost exclusively upon her daughter and kept it sufficiently concealed from others to the degree that they viewed her as a kindly self-sacrificing mother.

The mother was quite two-faced, or, as is said, *ambivalent*, towards daughter, for while she hated daughter, at the same time she took pains to see that daughter was attractive, well-mannered, well-educated. Daughter was mother's pride and bitterness at the same time.

There were hundreds upon hundreds of occasions when mother made daughter feel that she was making life miserable for mother. If daughter was a few minutes late in returning from school, mother's pretended hurt was dramatized with the idea that intolerable severity had been imposed upon her. She was always acting as if she were dying. On other occasions she threatened suicide, because she felt she could no longer bear up under the daughter. She used to leave home for a day or two on the pretense of going to kill herself, but later daughter would hear about the delightful visit mother had made to friends in another part of the town. Enraged at daughter, mother said one day that this time she was surely going to commit suicide. It later turned out that she pleasantly joined friends at the railroad station; all went to a gay seashore resort, where they spent several happy days.

When the daughter—our patient—was seven years old, mother gave birth to a boy. Mother promptly found fault with him, asserting that the shape of his head was irregular and she would therefore have to put him into an institution. For the next many years this threat kept the patient and later the boy in anxiety.

Whenever ill, no matter how minor the complaint, the patient

(the daughter) was immediately put to bed, candles were lit and the clergyman called to administer the last rites. Thoughts of dying crushed the child's mind, yet the mother also built the child up to occupy a place of consequence in good society.

Mother spent large sums of money on daughter's dresses, so much indeed, that friends and neighbors promptly recognized how beautifully daughter was dressed and how plainly mother was. When that topic came up for discussion among friends, mother made it a point to stress daughter's ingratitude. Many friends of the family grew to hate the daughter, who was violently warned by mother never to complain about her, lest she suffer the rest of her days for causing the mother to commit suicide.

It must be said that this little family was highly respected by the community, even with such an irreverent daughter. Mother was an active member in civic clubs, outstanding for her efficiency and devotion. Father was a calm, kindly man, soft-spoken, with an easy smile. The children were sent to the best private schools and "enjoyed" benefits that only the well-to-do could afford.

When the patient was eighteen years old, she took secret delight, very secret, in joining a professional group of high caliber. It was not long thereafter that she was courted by a young man, whom she quickly married. After they had set up housekeeping, mother moved in with them and began to circulate reports that the marriage was hastened to cover up illicitness and that the bridegroom was suffering from a bad venereal disease. The truth was that the newlyweds were entirely above reproach. Yet new rumors of a similar character grew from the self-sanctified mother.

Under unquestionable circumstances the patient had a child, not unquestionable, however, to her mother, who now began to pit the young parents against each other, and did not stop until they were legally separated. During the next several years the patient's mother "sacrificed" herself to the upbringing of her grandson. From the time that he was old enough to understand, the grandmother kept telling him that he was born of bad parents and whenever his mother (the patient) went out he was told that she was leaving him, never to return.

The patient was highly talented and progressed rapidly in her chosen field. In later years she mildly rebuffed the mother for her unkind actions, whereupon her mother, in a great huff, hurried off to relatives with her long tale of woe.

When the patient was 28 years old her mother died. One might think that with the mother's death a great load would have been lifted from the patient, yet, the habits of some 28 years were not easily altered. It is not an uncommon observation that *no matter what the imprint may be on the mind—love, hate, fear, irritability, inferiority, superiority—it continues as a fixed habit*, over which there is little control, save through treatment. Reared under the heavy yoke of domination and guilt, our patient was unable to shake off the burden, even though she knew full well that her life was blameless. What we get inured to we keep, even at a frightful cost to us. It seems so incongruous that human beings unwittingly yearn for the circumstances that kept them in abject servitude, even after the external causes for distress have been removed. What happened to this woman was not at all rare—after her mother's death she imposed, not consciously, of course, a more burdensome load upon herself than she had previously borne.

She began to feel that life was futile, lost the zest for her professional career, and acquired a sense of great weakness. She said she kept her chin up; no one knew about her suffering. On the contrary, almost all her associates clearly saw that she sought to place herself in humiliating situations with those who seemed willing to browbeat her. Psychiatrists refer to this form of submission as *moral masochism*, meaning that "pleasure" is derived from being subjected to emotional discomfort and injury. Under those conditions she affected a cheerfulness that her friends could not understand. Her closest attachments were with those who told her how dreadful she looked.

With time her general efficiency dropped to a degree alarming to others and finally she was advised by one of her friends to see a psychiatrist. She was treated for about a year and established excellent recovery, due, it is felt, as much to her many assets as to the psychotherapy administered to her.

Emotions can invade character traits to such an extent that the traits acquire the strength of morbid symptoms. This woman was nurtured in submission; and submission to great indignities was her pattern for living. The name that psychiatrists give to her way of living is *ideal masochism*, meaning humiliation and mental chastisement, especially by another, who is known as a *sadist*. Our patient also showed what is called *moral masochism* in that she always offered her cheek whenever she saw the chance of receiving a blow

Origin of Types of Personality

Although with a little forethought we recognize that there are different kinds of human beings from the standpoint of personality organization, in our daily activities we are apt to overlook that fact and to try to apply a set attitude, our set technique, to all people. We do not mean to do that, yet it is far less of a burden for us to use one tool for every job than to change the tools to meet the particular task at hand. This is but another way of saying that, much as we do not want to, we still find ourselves giving preference to our ways, our habits, often to such an extent that we inadvertently set ourselves up as the pattern of living. This is a decisive fault, because too frequently it produces results the exact opposite of those to which we are aspiring. We start out in life with the quest for health and happiness. We soon find out that harmony is contingent upon our relations with others, almost exclusively upon our emotional connections.

Until recent decades it was traditional to ascribe the responsibility for our moods to the state of our physical health. It is still too easy to charge irritability to indigestion or tiredness or to some alleged glandular fault. The human being is averse to facing the truth, namely, that it is *he*, not his stomach, who is irritable. It is a strange twisting of logic that encourages a man to claim personal responsibility for his happiness, but to blame a poorly cooked meal for his grouchiness. When *he* is contented, when *he* has accomplished something worth while, *he* wants everybody to know that *he*, his ego, his mind is to be credited for the success. We are yet to find the man who modestly gives his stomach or heart or lungs the credit for the

high station he has reached in life. He knows, and everyone knows, that *he* is entitled to the honors. Is *he* also responsible for his failures? Not very often.

The organs of his body are man's handiest alibi. A headache, real or fancied, is an unquestioned excuse for the failure to perform a duty.

Emotions are our most potent possessions, yet we devote so little attention with a view to understanding them as such and we give still less appreciation to them as they appear in others. It is realized that exception may be taken to the expression of such a point of view, but it cannot be denied that we do not look under the hood until the car stops or sputters along, and then we usually do not know at what we are looking.

According to the most reliable information at our disposal today, there are *several* more or less well-defined *categories of character*. They are not sharply delimited in all respects, but the core of each is sufficiently characteristic to give it a special stamp. It seems that the framework of personality is laid down at birth and is dependent upon prenatal influences, of which there are two major factors, first, the *genes* (the elements that grow into adult organs), and second, the conditions under which the genes develop within the mother's womb. While there is considerable information on hand about these two factors, too little is known to warrant a reliable opinion regarding their influences upon the potentialities for personality organization.

VARIETIES OF CHARACTERS

It is known, however, that the yarn from which the final fabric is woven varies from individual to individual, not alone in strength but also in substance. *Biologically, all men are not born equal.*

(1) Some are born as *shut-in* characters; they are quiet and self-contained, remain essentially solitary, aloof even to their parents and, of course, more so to others. This representation of character is larval in that it masks the true character of the species. There are all grades of shut-inness, from the very mild to the very ex-

treme. This type of personality is recognized also under the heading *introversion*, the more pronounced forms of which take the term *schizoidism* (the state of being split off or separated).

(2) A second type of basic personality framework is built of *extraverted* traits, the infant exhibiting outgoing tendencies, always reaching outward for things about him, being fretful when alone, showing quick and striking changes of mood. He is full of energy, in contrast with his schizoid neighbor who shows diminished energy output. Another term often used to describe him is *cycloid*.

These two general types gain distinction in virtue of the direction in which their energies are expressed, the shut-in confining them largely to himself, the outgoing aiming them at others. These features are mentioned as guides for the management of children and not for their academic values. *They have great practical bearing upon the subsequent behavior of the child* and unless the extremes of personality structure are brought within average range there is high probability that faulty adjustment may dog the individual. It may be said that from observations to-date the responsibility for the harmonious development of personality in many individuals rests upon the parents, though it also seems well-established that other groups of children grow up imbalanced in spite of reasonable methods of upbringing. While the whole field is open to considerably more research than has thus far been done, it is true that a fairly reliable inventory of the child's emotional capacities and the parents' influences upon them can be made before the termination of infancy (about the fifth year).

(3) There is a *third* type of personality, one that appears to depend upon neither introversion nor extraversion. Just what it is originally associated with is undetermined, though the traits may appear within the first few years of life. Theories about its origin are unconvincing, but the fact of its existence is not. Some children show rather early the inclination to keep much of their mental energy bound to their organs. They grow up organ-minded, and less mind-minded. Some of them seem to develop that

way without parental guidance, though from the purely practical point of view psychiatrists assume that the parents often enter vividly into the development.

Body-mindedness is a part of normal, healthy growth and exists naturally throughout life. Sometimes its dominance continues in ways that it should not beyond the years when it should be essentially lessened. There are many ways in which body-mindedness manifests itself; usually, however, it does not stand alone as a symptom or group of symptoms, but is associated with mental symptoms such as obsessions, compulsions, fears. From the standpoint of preponderance of symptoms, *the severest form of body-mindedness is that in which almost all parts of the body are involved, and to which the name hypochondriasis is given.* There is another condition in which the entire body and mind feel weak and tired; there may be local physical complaints, but they occupy a secondary role in the patient's troubles. The term *neurasthenia* designates this type of illness.

In both hypochondriasis and neurasthenia often the personality itself *seems* relatively intact, perhaps, because the troubles are concentrated upon the physique. It is conceivable, too, that in certain individuals a constitutionally weak physique may play a greater or lesser role in the development and continuation of these disorders, although no proof of it has as yet been established.

(4) After this group of individuals who are largely body-minded is a fourth group in which physical and mental symptoms are more or less equally divided. No special name is given to the class as a whole for the reason that "local" hypochondriasis, that is, hypochondriasis of one or two, perhaps, three organs, can be associated with different kinds of mental symptoms. When such physical complaints are seen in patients with the *hysteroid* type of personality, we say the patients have *conversion hysteria*. When seen in a compulsive-obsessive character, it is said that he has a *compulsive-obsessive neurosis*; it is true that this *organ neurosis* is a "local" form of hypochondriasis, but the psychiatric classification of his disorder is based upon the type of character formation with which the disorder is associated. The same holds true for introverted and extraverted individuals, as well as for other groups. Not in-

frequently an organ that is very definitely out of order physically also has superimposed upon it a neurotic element, which appears to be secondary to the organic disease. For that reason the diagnosis preferred is that of the earliest-appearing disturbance.

We have discussed these body-minded groups in some detail in order to obtain for the time being a survey of the relative distribution of the emotions in the body and mind. What we do not know exactly is how far back in the life of the individual the fixation of emotions in the body extends, that is, what part inheritance may play, what share factors of growth within the womb and after birth may contribute. What we do know is that these several anomalous personality "types" now and then appear in the first few years of life, sometimes before the influences of the parents have operated long enough to create them.

In expressing opinions this way, we wish to stress that the full responsibility for the appearance of personality reactions cannot be placed upon any one set of factors (genes, intrauterine or extrauterine development, parental disciplines, etc.), because it is highly likely that each shares in the formation of the final structure of the personality. The known elements that lend themselves to study and modification comprise, earliest of all, the physical behavior of the child, and next, the nature of the child's experiences with others, particularly with the parents.

It may be mentioned here that in the life of the average individual, the earliest recallable experiences to which psychoanalysis can go back come from about the fourth year and ordinarily the recollections are hazy, as well as sparse and few. From that year onward memories steadily increase in number. But the very foundation of character formation is explorable by objective examination only, and under present knowledge is modifiable only by direct action upon the child in the period of infancy. Hence, *in this crucial period of development, a large part of the responsibility for the proper casting of character traits falls directly upon the parents or their substitutes*. There are no current techniques by which any substantial number of memories antedating approximately the fifth year can be brought into awareness.

It is possible, so it seems, to recover *energy*, but not memories,

from this very early period. Many so-called body-minded patients, in whom it is presumed that their troubles started in the infantile period, behave like infants. They "*speak*" a *body-language*; often in the form of tantrums or grimaces or peevishness or by assuming the posture of an infant. They really cry for attention and may flail their limbs about when not getting what they want. They may yell and scream. Certainly this behavior looks like a throw-back to infancy and the appearance is frequently supported by what the patient says. It is not at all uncommon for a patient to assert that he wants to be an infant again.

It seems that the explanation for such infantile activities may rest in the theory of *body-memories*, in contradistinction to *mind-memories*. The body remembers and repeats. Some patients say *that they do not think, their bodies do*.

From the standpoint of practical treatment in the later years of a patient's life, it is evident that psychiatrists lack a therapeutic method of approach to body-memories, equivalent to their means of approach to mind-memories. For more than one reason, therefore, it appears highly desirable that *psychiatry should emphasize and re-emphasize the value of training the infant*.

The parent who does not know what to teach cannot teach. We know more about our automobiles than we do about ourselves and our children. It would be premature, therefore, to try to bring up a child properly, until we are reasonably sure that we know how to bring up ourselves. All the information we have on the question of *child guidance can come to naught, if one-half of the child, namely, the parents, is not emotionally equipped to do its share*.

To review briefly what has thus far been described in this chapter, it may be noted that there are present at birth two recognizable frameworks of personality, namely, of introversion and of extraversion. If there are others they have not yet been sufficiently delineated to warrant inclusion as a type, except the type consisting of a more or less equal balancing of the two (*ambiversion*). Then, beginning at birth and continuing for a variable period, the original framework is so well-nigh completely filled with what we have termed body-mindedness, that every child, during a certain period

of life, has a body-minded personality. Therefore, in the rearing of the child, and certainly also in psychotherapy applied in later years, it is of practical significance to recognize thoroughly the nature of these *three fundamental personality structures: body-mindedness in association with (a) introversion; (b) extraversion, and (c) ambiversion* (from the Latin *ambi*, on both sides equally).

When the child becomes *mind-minded*, that is, when mental energy is partly drawn from the body and put into the service of ideas, judgments and memories, the influences of the parents become paramount in the aggregate of external forces that partake in the organization of mental-mindedness. We have already seen how the instinctual components of the child are controlled by the parental code of behavior, called the *super-ego*. It is believed that in a mentally well-balanced child, as it grows older, the instinctual impulses and the super-ego become relatively independent of each other although they are closely related in the beginning. This means that *the instincts reach the environment by going around, not through, the parental code*. For instance, when the child begins to seek information on sex, he satisfies that curiosity through others, keeping his investigations as far from the parents as he can.

However, if the parents have set up a cordon around the child's innermost drives, it often happens that the drives become habituated to the control of the parents, since that control operates within the child's mind. This is a situation that commonly leads to mental tragedy, because the instincts, despite great resistance on the part of the child, consort with the parental images and are in harmony with them. During the early years of childhood this is often recognized as an unholy alliance, whereupon both the instincts and the parental images are driven out of consciousness. They are driven *into* the mind, deeply into it, out of sight, into what is called the unconscious part of the mind. The final disposition of this combination of instincts and parents—known as the *Oedipus complex* in the male, the *Electra complex* in the female—is perhaps the biggest single factor in determining the child's mental adjustment in the years to come. It is the pivot around which psychotherapy revolves, and the hazard of overestimating

its supreme significance is slight, because experience demonstrates that mental stability is achieved as soon as the child's instincts, through natural growth or the formal techniques of psychotherapy, are shunted from the parents and parental images upon individuals whom society recognizes as eligible mates.

The process of growing away from the parents, that is, of diverting the instincts from them, is difficult and long, even when all conditions are favorable. Under the best of circumstances one does not make the change without cutting deeply into the feelings. It is easy to understand, then, that the shift is often a source of morbid anxiety to many, made worse by the fact that the forces that keep the instincts and the parents together are not within the reach of conscious management. It is a tragic situation, holding the individual in a sort of unseen and unmanipulatable vise.

That this is true is attested by the fact that the psychoanalysis of apparently well individuals results in the revival of the Oedipus or Electra complex almost in its original form. This is accomplished through artificial means by getting the individual to carry his emotions back through successive stages to early child-parent situations, at which juncture the emotions carried back are united with those normally remaining there, and thus original scenes are re-enacted. Subsequently the emotions and the instincts from which they spring are withdrawn from their earlier attachments and put to adult use. Normal individuals who go through psychoanalysis do so for purposes of freeing themselves from conflicts and complexes in order that their own emotions might not impede them while they are psychoanalyzing others.

If it is a prerequisite for a parent to be emotionally stable in order to achieve best results in bringing up a child, then surely any substitute for the parent—and a psychiatrist is just that—should have his own emotions well-regulated. He should be psychoanalyzed. Otherwise the patient is in double jeopardy, for he then has one parent inside and another outside him. The psychotherapist should be able to be objective and unbiased, at least from the standpoint of his own infancy and childhood.

Other substantial evidence of the Oedipus and Electra complex

comes through the analysis of those suffering from symptoms. This complex is an invariable part of the emotional life of all full-fledged psychiatric patients, in whom it appears to be an original source of great difficulty. All symptoms, of course, do not stem from it, but the greater number of patients possess the complex in a position of nuclear importance, around which other complexes are as satellites.

When the Oedipus or Electra situation has become entrenched in the sphere of the unconscious, straining to break out into consciousness, the individual is beset with *anxiety*. He loses the power to concentrate on his immediate daily problems, because the complex is sapping his strength. During psychotherapy, the enemy—and the complex is the severest foe against which he has ever had to contend—finally capitulates. But often the process in recapitulation is almost as intolerable to the patient as the original complex. *Psychotherapy is the sharpest instrument known to man*. It is the equivalent of performing an extensive major surgical operation upon a patient without an anesthetic. Perhaps this ought to be explained a little, lest it might be gathered that psychotherapists are sadists. It is not the technique of psychotherapy that hurts, for the technique is mild and innocuous. But, the coming of the ruthless, animalistic, instinctual inner impulses into consciousness is the double-edged sword. It is no wonder that, confronted with the choice of the two evils, some patients cling to their neuroses rather than face and, sometimes, be destroyed by the very impulses which they loathe. *Psychotherapy must be slowly, very slowly applied*. The pent-up instinctual impulses must be released very gradually and cautiously.

A neurosis or psychosis is the result of the *release of the terrific energy* from the complex without revealing the complex itself. In principle, it is nothing more than a process of which we are all aware. For example, when a man is intensely angered because his superior has humiliated him and he cannot reciprocate in kind, not infrequently he holds his temper until a chance to explode with immunity presents itself, as upon the office boy over some inconsequential error. The boy feels the hurt, knows that the chastisement is out of all proportion to the error, but he is at a loss to ex-

plain this perplexing outburst, as he has no way of tracing the anger back to its source. Nor does the man who punished the office boy realize that his lashing anger should have been properly vented upon his superior.

The principle is not essentially different when the punishment stems from the realm of the unconscious. Let us assume that the unconscious conflict is relatively mild, yet intense enough to be felt. Upon release from the unconscious it may bind itself to the character traits of the individual, causing them to appear in exaggerated form. A meticulous person becomes more meticulous; his fussiness regarding accuracy bothers him and others. He comes to be known as a nervous bustler. He is impatient to get his work done, but to get it done very correctly. Everything must be right with him. He pesters himself and others with his punctuality, his thrift, his insistence upon the truth. His associates are right far more than they suspect when they chide him about his conscientiousness.

He is known as "a character," as, indeed, he is. The traits he exhibits are admirable in and of themselves, but with the overload of emotions they also become nervous manifestations.

The same general idea prevails with respect to other types of individuals. The quiet, sensitive person, burdened with an Oedipus or Electra complex, withdraws further from contacts with people, because he feels that remarks made to him, even about others, are intended to embarrass him. He sees slights when none is meant. If he found it difficult to speak formerly, now with the complex pressing him there are long pauses in each sentence.

If the complex appears in an open, extraverted type of person, the excessive energy, coming from within, gives rise to overtalkativeness, oversociability, perpetual motion or, since he is the type likely to swing to an opposite state, to paucity of speech, aloofness to friends, and general inactivity.

These individuals do not show morbid symptoms; they are not popularly known as "mental cases," but are said to be nervous. If they are more or less constantly "high-strung," they are called "characters." Psychiatrists say these individuals have a *character neurosis*.

In the next grade of severity, in which the energy of the Oedipus complex cannot find adequate outlet through the character traits of the individual, the energy is transferred to symptoms proper. It has already been shown how the mental energy can invade one or more organs of the body, making it appear to the patient and others that the person is afflicted with an organic disease. Now we wish to show that the mind has its own special kinds of symptoms as significant in their way as are the symptoms of organs of the body.

Before giving clinical examples of the symptoms of the mind, let us first lay down the general principle that *in organic disturbances, of course, except those on the surface, the patient does not see the origin of the disturbance, but is forewarned by symptoms that disturbance is on the move*. For instance, when the appendix is inflamed, we have no knowledge of that fact; all we know is that we feel sick "to the stomach," that we have no appetite and are constipated, and that there is pain in the abdomen. The physician gathers the facts of the history of the illness, arranges the signs and symptoms in order, and, with these before him, concludes that the aggregation of data points to the appendix. For each organ of the body there is a *more or less clearly defined set of facts, called a syndrome, that gives a clue to the organ affected*.

When the mind works improperly, it, too, has ways of warning the individual of imminent trouble. First there is the feeling of uneasiness, a sort of general letting down, with corresponding reduction in the usual efficiency. This is more or less characteristic for all ailments and gives no indication of the source of the trouble. With time there is an intensification of the general feeling of sickness and languor, followed by a pointing-up of symptoms, vague in their early manifestations, but subsequently becoming more and more crystallized.

The general sense of nervousness and the physical debility are no help in localizing the ailment; they are simply the preliminary warning that all is not well. There may still be considerable confusion in the mind of the physician, if the emotional disorder seeks refuge, so to speak, in one or more organs of the body, thus making

it appear that the trouble may be *organic in origin*, when in truth it is *organic in effect*. However, the disguising is not easy to detect, particularly in the early stages, because the organ into which the emotions have gone has no way of warning the individual of the cause of its troubles: it can only send out a distress call for help. Therefore, we are still without anything definite from the standpoint of cause.

The most sensible step to make next is an intensive examination of the individual from the physical point of view. This should come first, because physical causes may spread relatively rapidly, producing a breakdown in the tissues of the body or organ involved, whereas, *when the cause is emotional, there is very slight risk of immediate physical disruption*, even though the symptoms may be more alarming. All physical tests may be uninformative and still the basic cause may be organic. It is a fault, however, constantly to repeat physical tests, without also making familiar tests with respect to possible emotional causes.

It must be understood that any organ of the body may send out warnings which mean that the organ is not properly performing its duties or functions. The warnings are *symptoms* and as such do not give any clue as to *why* the organ is not working well. *Symptoms are not causes, but are the effects of causes*. This last statement should be underscored several times and repeated over and over again, because doctors and patients all too frequently regard and treat the symptoms as causes. This major blunder is very common when the cause is not immediately ascertained. Moreover, since patients with an emotional conflict are reluctant to face the cause, they easily fall into the error of confusing cause and effect. Surely their symptoms cause distress and the distress itself is a symptom. *Symptoms, however, are only reflections of causes*.

Experience teaches that the usual heart disease of organic origin progresses within a given range, with generalized reduction of activity, relatively easy fatigue, and perhaps with increased breathing under ordinary exertion. This may be followed by oversensitivity to lower temperatures, then by the sensation of pressure in the chest and a feeling of faintness and dizziness. At this time

physical tests may still be negative, but with intensification or continuance of symptoms, it is highly improbable that the organic origin of the trouble will not show itself more or less definitely in one or more tests. The examination of the patient is incomplete when unrevealing physical tests are repeated for months or years, as they too frequently are. The same may be said about any organ of the body with due allowance for very slowly growing physical disturbances.

There is far less difficulty in determining the emotional origin of "nervousness," when the mind uses mental rather than physical symptoms to signalize the presence of underlying disorder. This has already been exemplified in the form of exaggerated and turbulent character traits. When the latter can no longer hold the deeply rooted complex in rein, there is a gradual transition of the emotions from the character traits to formal symptoms. With the Oedipus or Electra complex, still as a leading example, we can see that the overpowering, unconscious combination of the patient's instincts with the parents gradually compels the son (or the daughter, as the case might be) to act and feel close to the mother and distant to the father.

A son, in his late twenties, began to court a girl on the assumption that it was about time he grew away from his mother. He sensed that he was happy with his mother, but his brothers, sisters and friends had been twitting him more frequently within recent months, because he spent almost all his hours with her. They suspected that he had changed the nature of his work about a year before in order to be with her more of the time. He used to work in an office from which he telephoned to her several times a day, asking how she felt, even when the inquiry about her health was uncalled for. He changed to an entirely new kind of work that made him independent of his immediate boss, who occupied the role of a substitute father to him. From that time on he had his mother with him daily on his trips to customers. Among the latter, it was common talk that the two were inseparable.

As the companionship acquired greater constancy, quarrels began to crop up here and there usually over trivial matters, "like the

ones I always used to hear," explained the patient, "between mother and father." It was becoming increasingly obvious that the relationship was taking on the character of marriage as he understood it. Indeed, his brothers and sisters resentfully expressed it that way. Steadily the son became restless, irritable, mildly confused. He used to be gay and cheerful, now he was morose, began to question the meaning of living and developed a what's-the-use philosophy. His conflict was being expressed in the form of character changes. To indicate that the character traits are playing a scapegoat role in bearing the burden of the troubled mind, psychiatrists use the term *character neurosis* in the belief that the character traits have the effect of a neurosis without the more familiar symptoms, such as disabling fears, obsessions, compulsions, etc.

He thought of parting from his mother, but he was shocked by the idea of her being alone throughout the day; father had died some years earlier and the brothers and sisters had married and set up homes of their own. The patient rationalized that it was his duty to stay close to his mother.

To paraphrase Eugene O'Neil, "Mourning Becomes Oedipus." He was an unhappy man by this time. The warmth that used to prevail between mother and son changed to coolness, thence to irritability, to sadness, to psychological rift. This series of emotional steps was experienced by the son, while mother used all the means at her disposal to keep up the former cordiality. In fact, she succeeded in drawing him more closely to her through her constant endeavors to cheer him up, endeavors which he accepted and rejected at the same time.

It was evident that he wanted her and he did not want her. It was the old story of being unable to go on with or without her. In this stage of morbid indecision, which spread from mother to business, to their occasional recreations, he purposely set out to find a girl to whom he might attach himself. However, the die had been cast; the Oedipus complex was too firmly set in him to permit any bond, save a flimsy one, between the girl and him. Moreover, as soon as mother saw the likelihood that son might shift his feelings from her, she developed a nervous stomach, about which she com-

plained with considerable fervor, but for which she would "certainly" not go to any physician. Her refusal to seek medical advice had the double advantage of keeping the truth of her stomach troubles from her and of drawing her son even closer to her.

The prospective fiancée realized the buffer role she was playing. It irked her to know that she was simply a cushioning device for deadening the concussion between mother and son. The proof that she was such came often to her, because son seldom kept an appointment unless his mother was along, too. Had there been a meter for measuring the emotions while the three were together, the indicator would have stayed constantly on the mother-son beam, the "fiancée" merely serving to prevent outward manifestations of the intense feelings. Several months after the beginning of the "courtship," the girl gave up in despair.

Morbid indecision, which had partly abated, returned in greater measure until son had to give up his work on the assumption that he should get work that did not call for independent initiative and judgment. It did not seem "just coincidental," as he put it, that he gave up the job which kept him close to his mother at the time that he was losing the girl to whom he became engaged to distract him from his mother.

He secured a new position, this time in an office in which he worked under specific assignments. He felt relieved, because he no longer had to make decisions, for he worked by rote. The more important reason why he felt better, his not being physically close to his mother all day long, never occurred to him. Nor did he connect the improvement of *her* stomach trouble with the exit of the girl friend. Moreover, this same man who only a short time before could not tolerate a boss (a father surrogate), this same man who yearned for the independence of maturity, now did a complete about-face. He took a job in which subordination was a first requirement. In other words, he demoted himself, he regressed. By these changes in his way of living, four basic conditions came about. First, he lost his girl, second, he acquired a boss, third, he gently reduced the time he spent with his mother, and fourth, he felt inferior, "like a youngster," as he expressed it.

However, the Oedipus conflict in the unconscious was not resting. Nothing had been done to draw the excess of emotions from it. Morbid indecision shifted from his work to his diversional reading. He could not decide whether the names of characters in the book were those of persons whom he had known or not. He fretted so greatly that he could not follow the story of the book. He read and re-read passages, but all was confusion. Names became an obsession with him, forcing themselves upon him, until he could not successfully do routine menial work. The names kept recurring, but they meant nothing to him, though he had a vague feeling that they were those of friends of his earlier years.

The obsession grew so intense that he was unable to recall the names of his everyday friends and associates. He was literally bombarded with names that seemed both familiar and strange to him. He was so perplexed, he said, that he did not notice that the names were feminine. As we looked further into the growth of the obsessions, it developed that they were the names of middle-aged women.

Like fears, delusions, and hallucinations, obsessions often grow imperceptibly from inordinate emotional bonds such as illustrated in the foregoing. The development of this patient's obsessional thinking is characteristic in certain general principles. In the first place, insofar as he knew in the beginning, the names that plagued him were *undifferentiated*. All he knew was that he was bombarded with them. The anxiety was so severe as to preclude the possibility of his seeing that they were names of women only, and that, moreover, they were the names of women old enough to be his mother. Of course, he could not then realize the fact, very obvious to others, that his mind was preoccupied with women, women, women—older women, who beset him.

In the second place, he could not connect the appearance of the symptoms with the simultaneous trouble he was having with his mother. Once he made "the great mistake" of telling his brother about his "name trouble." Brother responded that the patient was a mama's boy. That statement ended cordial relations between the two. *Patients never look into themselves, into their ways of*

living and thinking, in an effort to see whether their symptoms may be associated with their ways of living. The reason why they do not is obvious. They are not going to see what they do not want to see. *They cannot be expected to destroy their defenses.*

In the third place, in the unconscious effort to guarantee that he will not know the original cause of his trouble, *symptoms are pyramided.*

Slowly the names of others caused him distress, then names in newspapers, magazines, on billboards, etc. As a sort of assurance against any insight into the meaning of the obsession, the names of men, too, flowed in upon him in great profusion. This meant that the conflict with the father, too, was creating symptoms. Then numbers began to plague him. It will suffice to refer to one of the latter. For some three weeks a telephone number made him almost insane, as he expressed it. He had no inkling whatsoever of its meaning; all he knew was the incessant hammering "on my brain" of the number. During treatment it came out that the number was one that he had called hundreds and hundreds of times—his mother's.

In the fourth place, *there is often a special kind of memory loss seen in emotional states.* Emotions can block out whole events of a person's life, as in the case of a man who had no memory at all concerning his married life, which was then some three years old. Yet, he held a position of great responsibility in virtue of his memory (for other things). Another patient was totally unable to recall a single incident with her mother; she could not even picture what her mother looked like. But, she had vivid memories of her father. A third patient, a young lady married a few years, had an exceptionally good memory for events of the past, though she had absolutely no knowledge that she had been courted, that she wed the man and had a child by him. Memory is elusive for the things we do not want to remember. Emotions can erase memory from the conscious mind, while at the same time they fix memory securely in the unconscious.

The point to be emphasized is the meaning of symptoms in the life of a patient. They are certainly not haphazard mental phenom-

ena. Until a patient is psychoanalyzed they seem to him to be destructive material' completely isolated from anything connected with his life. He stands helplessly by, while he is being destroyed; he has no defense against them. As far as he is aware, he had no part in the development of the symptoms. He is truly victimized by his unconscious complexes, tormented by them.

Would you not think that it would be far easier on the person to admit his complexes—in their full crudity—to his conscious survey and judgment? He seems to suffer more from the symptoms than from the cause, but, of course, he has no such choice. It is all a subtle process, done without awareness and with a severity that is out of all proportion to the betokened crime. From the standpoint of man-made laws no offense has been committed, nothing unlawful has been done. But, the court of judgment that holds sessions deeply within us sentences us without any semblance of a trial and more harshly than would a real court, apprised of overt acts. A psychiatric patient, rather the unconscious of such a patient, is the cruelest beast known to man, and this is not a figure of speech; it is the plain language of those beset by turmoil that arises from within themselves.

Those patients in whom the unconscious complexes either break through more or less abruptly, as they do in the manic phase of manic-depressive psychosis, or bore from within until they finally overrun the realm of consciousness, as they do in schizophrenia, first with the tacit, then with the active consent of the person, those patients do not suffer, perhaps because moral judgment is suspended. The price that the patient pays, though, takes the form of a *psychosis*, which in the final analysis represents the triumph of the instinctual, animalistic impulses over the refined requirements of society.

In this chapter we have become familiar with the fact that when emotional trouble is brewing beneath the surface, rumblings of impending danger may be heard faintly at first, but a little more clearly as the forces from the distant unconscious gain momentum. The particular way by which we respond depends upon: (1) the strength of the enemy; (2) the strength of the conscious forces;

and (3) the type of personality against which the battle is waged.

The shut-in person habituated to the avoidance of conflicts by merely drawing away from them, soon finds out that he cannot run away from himself.

The extravert manages for a time to fend off enemy action with his usual weapon to hold up the enemy's progress by erecting a barrier of incessant activity within the environment. He puts dozens of irons in the fire only to find out that most of them cool off before he is prepared to shape them to his use.

Instinctual Impulses

For many years now there has been general agreement among psychiatrists that there are two great subdivisions of mental disorders, namely, those called the *psychoneuroses* or *neuroses*, and the *psychoses*. The names themselves are not particularly significant; rather they are more interesting from the standpoint of semantics than from that of scientific classification. Quite apart, however, from nomenclature, there is a natural subdivision into two groups.

As in most branches of medicine the conditions that are ordinarily first described are the most obvious ones. Investigators in psychiatric matters are no exception to the rule. The result is that the public is introduced to any new illness usually in its severest form, and an impression is created that is difficult to get away from, especially when milder or earlier manifestations are described. It is a long, long time before people act on the question of preventive medical procedures, first because they carry in their minds the original concept of the disease in its devastating form, second, because they are averse to taking treatment until they have been incapacitated.

Psychiatrists first busied themselves with psychiatric wrecks, with that unfortunate kind of human derelict who grovels "on the ground as a miserable sinner and stands up to declare that he is the channel of Divine Inspiration" (Leslie Stephen, *Apology for Plain Speaking*, p. 307). They are the poor creatures who in their distraction lead an animalistic type of existence, with all the primordial instincts characteristic of man in his earliest forms. These human likenesses were first gathered under the same roof, where they were held in contempt and awe. In some communities they

were sanctified, as they still are today in certain localities, but generally they were abandoned to the elements. Patients of this order have always been with us and it is but true to say that they constitute a frightful sector of humanity, made far worse by the scorn and neglect on the part of the public.

That this should not be so is all too clear to the scientific world, for these are unfortunate beings who through no fault of their own are emotionally imperiled by their instincts, and perhaps also by faulty organic factors. They are sick and in misery and they merit our scientific attention every bit as much as do patients with advanced tuberculosis or cancer or any other debilitating disease. Today the vast majority of these pathetic figures find not the slightest trace of sympathy from public officials, who in the final analysis take their assignments from the population at large. Today we are only a little further advanced beyond our forefathers in the matter of providing for their daily needs.

It is not our problem, however, to complain about the inertia of the public because it is not yet prepared to work energetically with the scientific advances, small as they may be with respect to the patients who could say: "I have lost the immortal part of myself, and what remains is bestial" (Shakespeare, *Othello*, II, 3).

That these patients exist there is no doubt. They are not being neglected at all by the medical field, which has been alert for years to all new techniques of investigation and treatment efforts.

Until about a century ago, when research work in psychiatry began in earnest, attention was converged almost exclusively upon those patients having a *psychosis*, that is, having a *mental disorder of such severity as to warrant hospitalization*. This group was large enough to require all of the efforts of the small band of psychiatrists then in the field. Furthermore, these patients constituted a mixed group, many of whom were mentally ill in association with organic disease, while others were not known to have any such disease. The earliest clinical tasks of psychiatrists comprised a separation of the patients into diagnostic categories. Slowly over the years two large groups emerged, consisting on the one hand of those who had recognizable organic disorder, and, on the other,

those whose mental symptoms could not be identified with tissue changes. Today the two large groups are far better defined than they ever were, thus creating a research atmosphere that lends itself favorably to studies on each group.

In the second half of the last century, psychiatrists initiated more intensive studies into the mental aspect of mental disturbances. The idea began to take hold that there was a biology of the mind, called *psychobiology*, as well as one of the body, *somatology*. Psychiatrists began to group symptoms into entities, observing that certain symptoms seemed to be commonly associated. Thus there grew up a series of diagnostic groups based upon mental symptoms, to which the term *psychogenic* (springing from the mind) was applied. Medical men were divided on the question of cause, but there was unanimity of opinion to the effect that the psychogenic "cases" showed a pronounced deviation from the standpoint of those qualities that stamped human beings as individuals in contradistinction to the more strictly physical aspects.

In those earlier years emphasis was still confined almost exclusively to the *psychoses*, which had two subdivisions of psychogenic "cases": one called *dementia praecox*, the other *manic-depressive psychosis*. Investigation seemed to point to the fact that the symptoms these patients presented did not appear to arise as things new and different, as organic symptoms did. They seemed to have connection with the past life of the individual, long antedating the development of full-fledged symptoms. Further experience showed that there was no sharp line of distinction between the phase of health and of disorder, the one merging often imperceptibly into the other. Then came the suggestion that perhaps the symptoms of the psychosis represented the climax of a distorted life, as a kind of solution to the individual who could no longer stand the stresses and strains of the environment. The totality of his symptoms seemed to point to this pivotal idea, and among other things, led to research on the influence of environmental stresses as contributing factors in the development of the psychoses..

Over the subsequent years baneful influences from the environment (bacteria, parasites, drugs, injuries, diet, etc.) were elabo-

rately studied, and still are, all contributing to a further clarification of the relative role of endogenous (springing from the body) and exogenous (originating outside) factors. These investigations, though not easy by far, have yielded enlightening results.

These earlier researches in the domain of psychogenic psychoses among advanced hospitalized patients were invaluable in showing the relationship of the past, "healthy" or symptom-free life of the patient to the symptom stage of living. But the vast array of information on this point was inapplicable as a treatment measure, largely because the patients were insensitive to it. As a rule, the dementia praecox patient in particular was not amenable to the various means by which he was stimulated to adjust himself to simple environments set up in hospitals. Even in such a sheltered setting he failed to participate in the recreational, educational, professional and trade programs put at his disposal. The world of his own phantastic creation was far more alluring.

Impressed by the possible value of gauging the role of the instincts in other kinds of mental illnesses—known in general as the *psychoneuroses*—physicians, particularly neurologists, began to apply the newer knowledge to this group. This was a most difficult task to undertake, because often there did not seem to be even a slender thread of connection between the former symptom-free and the subsequent symptom-ridden life of the patient. Once in a while, however, the symptoms disappeared while the psychiatrist or neurologist reviewed the patient's past life with him, and hope persisted that the doctrine was plausible.

Many men of scientific eminence gave their full time to this branch of research, out of which came the epochal investigations of Sigmund Freud near the close of the nineteenth century. It was he who saw, very faintly at first, a hair-slim connection between *body symptoms and emotional shocks in the early life of a hysterical patient*. As he dissected further the mental life and history of the patient, the bridging of the past and the present became ever clearer. Over the bridge he was able to lead the emotions out into the open, so to speak. He did not then know whence the emotions came, save that they arose from past experiences and under his

guidance they came to be made a part of the symptoms of the patient. To give a name to the process of cure, Freud spoke of *emotional catharsis* wishing to convey by it that pent-up emotions could be drained from their unnatural incorporation in organs of the body.

The view that life experiences are known causes of mental disorders gained further support under his researches. Furthermore, he demonstrated its value for the cure of symptoms. He had found a type of mental patient to whom an analysis of life situations could be successfully applied. This type was not the kind that needed hospitalization; however incapacitated, she (or he) managed to stay at home, often performing the daily tasks, or working for wages. Besides, such patients felt really sick and complained bitterly about their ailments. They were quite different from the average psychotic, especially the full-blown dementia praecox patients, who seemed not to be unhappy with their symptoms.

Psychiatrists were entering a new era. From an old tool they were fashioning a new instrument, psychotherapy, and they were beginning to wonder to what extent the new tool could be applied. Freud and his followers set about the task with a group of patients having special characteristics. They constituted that large element suffering from *psychoneurosis*. They are the ones who do not wholly succumb to their animalistic, inner drives. They are alarmingly troubled, but they wage constant struggle against their inner impulses. Their defenses are weak, yet strong enough to keep the hostile forces out of conscious range. They do so by erecting a barrier of symptoms—fears, obsessions, compulsions, physical complaints, etc.

As a corollary to the foregoing, the psychoneurotic patient ordinarily is able to keep a portion of his conscious aptitudes entirely or nearly intact. This means that, within given limits, he works in the environment, has social contacts, maintains diversional activities. Indeed, superficially, he gives as a rule the appearance of being normal, since, with the passing of time and experiences, he learns how to conceal his major troubles from others. Yet, a *psychoneurotic is a forlorn human being*.

It was to this group that Freud first began to apply the fruits of his researches. Two outstanding results emerged. First, *the patient's symptoms were correlated with his instinctual life*. For the first time this correlation, predicated for centuries, was put to practical and extensive application. Second, it worked successfully with many patients. Cures were established. The method, called psychoanalysis, attracted an ever-increasing number of psychiatrists, until today it is the outstanding form of psychotherapy, with a wide following in the field of medicine.

Taking their cue from Freud, psychiatrists, devoting themselves to the care of patients who had to be hospitalized, began to understand their patients better. They found that psychotic patients, too, had past experiences that were constituent parts of their psychiatric symptoms. In these patients, too, there was a continuity between their past and present. Their symptoms represented an abnormal culmination of a series of life struggles, much as the symptoms of the psychoneurotic patients did.

As research investigations continued certain fundamental surmises crystallized. It seemed that for some unknown reason the psychotic patient was unable to sustain himself continuously in his environment. It was suggested that, perhaps, he was too fixed to his infantile ways of living. Perhaps there is something lacking in his capacity to build up an adequate social form of adaptation. Possibly the basic structure of the personality is weak. Perhaps, too, there is an over-all insufficiency, physical as well as mental, that spells doom for the psychotic patient. These and other unsolved questions are under active investigation today.

These remarks do not mean that the outcome of all psychotic patients is poor. Many are helped by psychotherapy and other measures. Those who are helped are the ones who have had many good social assets to begin with and who, like the psychoneurotic patient, struggle against the dominance of their infantile instincts.

In the early years of modern psychotherapy, hospital psychiatrists clearly perceived that, to obtain the best results, psychotic patients should be in a hospital that resembled conditions in the environment as closely as possible. *The hospital should take on the*

aspects of a new home for the patients. Hence, the value of psychiatric nursing from the emotional point of view was considerably enriched. Classes in trades were established in hospitals; sociability was emphasized; so, too, were diversions and educational advantages. The hospital became a place for living, for growing up. Many of these tasks were, and continue to be, centered in a special unit called *occupational therapy*.

Since some fifteen or twenty per cent of dementia praecox patients and nearly all of the manic-depressive patients were able to leave the hospital recovered or improved, it appeared reasonable to test the new theory of psychotherapy on these groups at home. So-called out-patient clinics were established to which "paroled" patients reported at regular intervals in order further to unravel the life experiences that possibly shared in the development of their psychosis. The doctrine was put to further use through *social workers* who visited patients in their homes, often also giving them direct assistance in matters of social adaptation. The social worker became a sort of another member of the family, frequently helping to solve unwholesome relationships in the family.

Nurses in psychiatric hospitals were imbued with the same point of view, adding their personalities as a direct means of treatment. They became extremely valuable in the management of the patient's emotions; under their professional guidance a new atmosphere was created. For the wide application of this doctrine in hospitals great credit is due to Adolf Meyer, who was as kindly disposed to research in the mental sphere as he was to that in the physical.

All of this took place very slowly and gradually. Sigmund Freud centered his attention on the mental side. Observing that the experiences and their allied emotions that led to symptoms were forgotten by the patient, were out of the field of awareness, he felt the need of coining a term for the new concept designating the theoretical "place" from which the instinctual impulses operate. As a working hypothesis, which it still is, though a very practicable one, he called the *unseen realm of the mind* "the unconscious." Over the succeeding years he devoted himself indefatigably to

further investigations into it, finding it a rich storehouse of memories, many of which were still heavily crammed with emotions. Many of them were sources of potential and real danger, because, by a peculiar faculty of the unconscious mind, the emotions could and did violently escape from the experiences and by overwhelming the organs of the body or conscious mental activities induced sickness of the greatest violence.

The more deeply Freud penetrated into the *unconscious*, the nearer he came to surprisingly fresh streams of emotions; they were not new, but nearer to their fountainhead. It was as if he gradually took off the thick insulation made up of adult experiences that concealed the emotions; then he did the same with the experiences of adolescence, late childhood, early childhood, finally exposing, as well as could be, the emotions of infancy. The problem was to free the emotions from their unconscious attachments in order to make them available for current, social usage. In this process of liberation they were also detached from unnatural modes of expression such as body organs and morbid ideas.

It appeared that the Freudian concept of the nature of the instincts did not differ radically from that of many other investigators. For instance, what William James called tender-minded was, in terms of mental energy, the equivalent of the *erotic* instinctive component of Freud, and James' tough-mindedness was parallel to Freud's aggressive or *thanatotic* component. The division of the instincts into two groups of antagonistic nature was, in modified form, a continuation of Lord Herbert's theory, propounded in his *De Veritate* in 1625 and prevailing up to the middle of the nineteenth century. The original meaning of the word *instinct* as a "natural impulse" was retained by many researchers. After Darwin there came up another school of thought which defined instinct as a "congenitally organized pattern of behavior."

Throughout these chapters we have spoken of emotions and instincts as if they were one and the same thing. Academically it is not so, but for all practical purposes it suits our task to bring the two into such close alliance that differentiation is an unnecessary super-refinement.

In order to establish a starting point for the instinctual components Freud came to select *a theoretical region in the deepest layer of the unconscious, yet one that has direct continuity with tissue of the body. He called that region the Id. In other words, the energy of the instincts and their representations can flow from the Id with equal facility either to the physical or to the mental part of the individual.*

There are *special zones of the body that appear to draw instincts to them.* Freud placed emphasis upon three of these areas; a) the genital, b) the oral, and c) the anal. There is no need to go into much detail here regarding the investment of the instincts in these zones, because important as it may be, the management of the instincts in their earliest connections is the problem of the specialist. He knows the extreme difficulty, if not impossibility, of doing much about them, except as they cast their shadows upon the individual beyond the age of infancy; that is, the highly trained psychotherapist can recognize and occasionally do something about the later evidences of infantile activity in these areas.

It cannot be denied that throughout the life of the individual these three zones are intensely powerful, though in different degrees.

a) The role of the *genital impulse* is too well-known in general to require much other elaboration here, than to indicate its transcendent significance in the molding of character traits; furthermore, the part it plays is discussed in almost each chapter. The genital impulse is felt throughout the body, having primary representation in the reproductive organs and being invigorated through the five senses, as well as through posture, gesture, dress, etc. What appears to add greatly to the difficulties of sexual adjustment is the fact that such a foremost natural drive must be bridled by harness far in excess of its maximum explosive strength. Under normal conditions only a fraction of its energies is given direct outlet, while its larger part gains external expression through vicarious and subsidiary channels.

b) *The restrictions placed upon the oral zone, both by the individual himself and by society are relatively mild and tolerable.*

There is almost complete freedom of outlet for the love and hate impulses through the oral zone. It is well understood, therefore, why the mouth region often becomes highly sexualized in those individuals, whose sexual energies cannot drain off through the sexual organs. This shifting of sexuality is seen in very vivid form in almost all well-developed psychiatric states, in which the oral zone may literally substitute for the genital apparatus.

c) The *anal* region, too, is a source of constant activity, about which there is far less tabu than there is with sex, though there are more restrictions imposed upon it than there are in the oral zone. Normally the anal area is not subject to much trouble, but in psychiatric situations it may and often does gain a position of pre-eminence.

The two instinctual components, *erotic* and *thanatotic*, arising from the *Id*, flow through various internal and external organs of the body, and in so doing they come to stamp their body influences upon the mind of the growing child, giving rise to what is called *body-mindedness*. Some personalities are inordinately weighted down with preoccupations of their bodies, thus carrying over into adulthood an undue quantity of interests in their physical selves.

Under conditions of normal growth a large part of the instinctual impulses is gradually transferred from the body to the mind. In the mind the instinctual impulses attach themselves to character traits that are developing and in so doing they lose their infantile and overt body manifestations in favor of personality traits that are more readily able to be accepted by the individual and society. This transition involves the process of socialization of the instincts. It is a form of refinement, which in psychiatric parlance is called *sublimation*. However, the average psychiatric individual accomplishes the transition only in part; or the patient loses his good manners and conduct. He recedes from the social graces to the habits of his childhood or infancy. The instincts have not changed in any way, but their mode of expression has. In this respect the instincts are like an electric current, which in itself remains unchanged, but which may be used to drive a motor, light an incandescent bulb, ring a bell, shock a person, etc.

What is known by all, but what very few people pay close attention to—because they charge it to their nature and thus dismiss it lightly or justify it with a shrug of the shoulders—is the fact that they possess these two instinctual components, the tender and the tough. It cannot be too strongly emphasized that *these emotional elements are the very things by which we live in peace or disharmony*. They are the core of adjustment within the individual and with his associates. This sounds all too simple, but fundamentally it is the essence of psychiatry. The details are multiple and varied and the “language” of the emotions requires special study. All of this is within the grasp of the average individual, provided he is willing to give time and thought to it.

The treatment of psychiatric conditions is a fine and delicate procedure which requires extensive training and experience to apply successfully. It will be greatly facilitated when the public no longer recoils from psychiatry as if it were some horrible and outlandish monster, which it is not. The patient who stands in awe before it is too confused and frightened to gain from it. But he will not wince from it any more than he will from any operation when he knows the general nature and purpose of it. He need not know the minute details of the psychoanalytic operation before he starts—he will get them very gradually in the process of being analyzed—but when he has fair knowledge of what to expect and what the probable results will be, his co-operation will do much to insure its successful application.

Treatment procedures along psychotherapeutic ways give proportionately better results the earlier they are applied in the course of the illness. This proves as true with respect to the psychoses as to the psychoneuroses, though the latter are still in the lead. For some years now, psychotherapy also has exercised its effect upon individuals whose own personality is disturbing to them, though they have no morbid symptoms. To them the name *character neurosis* is given and with them preventive psychotherapy has so well proved its value.

Mental Energy

From the preceding pages we have gained the information that *the essential factors leading to the production of a psychiatric disorder are associated with the instinctual life of the individual*. What other ones—such as disordered physiology of the organs of the body—may be involved is still open to question. Possibly there are more cogent agencies, but until they are identified and can be put to use, we must accept and apply what we know. This conservative way of evaluating up-to-date progress is certainly not intended to run down its worth, but it would surely be unwise to be smugly satisfied with what we know.

While the most plausible reasons for the appearance of mental disorders are related to the instincts, we cannot stop with such a point of view. There is the apparently highly significant question of the *original quantity of energy with which the instincts are endowed*.

We see individuals who appear to have barely sufficient energy, both physical and mental, to insure something hardly better than a vegetative existence. They are unduly inactive on the physical side. From infancy onward they are quiet, stay in one place for unusually long periods, perhaps handling some physical objects, and one is impressed with their low ebb of motility. In childhood they do not romp around and when they try, in games, to keep pace with their more active playmates they are not quick enough to start and are awkward. They wish very intently to be a part of the game, but the motor power is not there and what is marshaled in a final drive to succeed is at sixes and sevens. These children ordinarily learn that the use of their intelligence brings them

more recognition than any form of motor activity. Consequently many of them put their energies into a single basket and become scholars, provided, first they have the potentiality, second, that they have enough energy to raise the potentiality to satisfactory levels.

A certain number of them fail to progress intellectually. They may have a very good intellectual apparatus, but there is not enough fuel to keep it going at a reasonable pace. Some peter out before they have gone through the grade school.

Usually those who show great deficiency of intellectual and motor energy also exhibit the same scarcity in the realm of personality traits. There is little or no drive to dress according to their station in life, to meet the ordinary social amenities, to be liked or disliked, to be honest or dishonest, to be egoistic or self-effacing. It would be nearer the truth to say that they have no personality or that it is very little in evidence. These individuals themselves realize that they are strikingly indifferent to all things, but they are equally passive to the recognition of their inertia.

Finally, when their unconscious sphere is examined and inventoried, there is not much energy found. They recount experiences of their past, not because they are interested but as a matter of accommodating the physician, who literally has to pump the individuals incessantly for each little drop of information. What does come out in dribblets has no "life" to it. So, too, with their dreams, which are not only few and far between, but also without punch.

It appears, therefore, that the individual's over-all energy is missing. There is no soft or tender emotional component, nor any hard or aggressive one. Until there are more refined methods of measuring the emotions, it seems that we may have to rely upon such practical observations as we now possess. It might be mentioned here that this type of individual is classed by psychiatrists as having the simple form of schizophrenia. *It is the only subdivision of schizophrenia the diagnosis of which depends upon paucity of energy.*

There are other individuals who show a relative preponderance of the tender, erotic element over the harsh, thanatotic one. It

seems that they are given to kindliness, gentleness and consideration that come spontaneously and sincerely from them, neither because they are afraid to assert themselves, nor because they feel that they must always appease others. They possess a reasonable amount of initiative and self-confidence and they are able to "stand on their own." They fall within the range of normality. Psychiatrists see but a very small number of people whose emotional energies are so balanced, and when they do come to psychiatrists, it is usually to tide them over some real difficulty generally of environmental origin. Their troubles ordinarily do not stem from the unconscious, nor from the conscious sphere for that matter. When external circumstances, such as illness of a loved one, agitate only the emotions in consciousness the outlook is particularly favorable for successful treatment.

There are also people with another arrangement of the tender emotional component that may or may not give rise to "nervousness." Some of these confine the tenderness and consideration to themselves, but do not spend it on others. They like themselves, live for themselves, are not at odds with themselves or others; they do not flaunt themselves at others, nor do they "flutter in brocade," as Pope expressed it. They are likable people, usually sociable and friendly, yet they do not share their hearts with others. They are narcissistic and untroubled. In the final analysis it seems that one of the best tests for normality or emotional stability has to do not so much with the nature and quality of the emotions, as with the use to which they are put and the way they are welcomed by the possessor and others. Extraordinary tenderness may very well be an asset or a liability to oneself or to others.

Of the two the role of the "tough," aggressive component is commonly of far greater importance to the individual. Normally the aggression of childhood forks off into two main branches. One division of it combines with the tender emotion to give strength and initiative to it, while the other energizes the daily routine activities of the individual, such as work, play, recreations. But this part, too, unites with a portion of the tender element, the two giving zest to one's activities. *This union of the instincts in the*

interests of comfortable living is known technically as the fusion of the instincts. Milton speaks of tempering justice with mercy. Maudsley (*Body and Will*) writes that "the altruistic impulse is formed out of the social fusion and transmutation of the egoistic impulses." In *Lord Bacon*, Macaulay said: "In the temper of Bacon—there was a singular union of audacity and sobriety." This observation had come down through the literature of the centuries. The only thing new about it is the use to which it is put in the field of medical psychology. It is a doctrine of prime importance in the understanding and treatment of emotional disorders. It is as much a part of medical procedure as a surgical instrument is part and parcel of an operation. Indeed, what is there in psychiatry that has not existed for ages? Certainly not the constituents of the mind. The only great difference, and it is great, is the scientific organization of the material and the methods of treatment arising from the organization and correlation. New terms had to be devised as the personality came under scientific investigation, yet there is no reason why such a term as *fusion of the instincts or emotions* cannot readily be grasped. Every day we are face to face with most of the basic doctrines of emotions and if we want any proof of them we need look for them no further than within ourselves.

Nor is it outside of our personal experiences to realize that these two emotional constituents can operate independently of each other, that is, that there is such a form of mental activity as *defusion of the emotions*. Love may exist alone. So may hate. When they do, the situation is at least provocative of disturbance.

Psychiatrists see very few patients in whom the aggressive impulse is not causing distress, usually *because it is alone and out of control. The patient cannot harness it to the constructive, soft-mannered emotion.* When severely out of control, it runs amuck, sometimes upon those in the environment, sometimes upon the individual himself. When the aggressive emotion turns inwardly upon the person, it is known as *masochism*; when environmentally expended in harshness towards others, it is called *sadism*. Often the terms are joined in order to designate their unity. What we have been calling the tough, aggressive thanatotic component is scien-

tifically called *sadomasochism*. It is related to destruction in contradistinction to the constructive emotional element, *erotism*.

From practical experience it seems that the quantity of aggressive instinct varies from individual to individual. Some have but a minimal amount, others a medium amount that works in harmony with its tender partner, while still others have varying degrees of excess, both relatively (to the erotic) and absolutely.

This whole question of the quantity of emotions originally placed at the individual's disposal may sound very academic, but it is really not so difficult to work with as it seems at first sight. Emotions are measurable, not with a scientific instrument, but surely with the meter of practicability.

What we have gained up to this point may be summarized as follows in a very general way. Human beings are born with energy, part of which is earmarked for more or less exclusive use in running the physical part of us, while another quantum is assigned to the mental sphere. How much reciprocity, if any, takes place is not determinable, but it appears that there is such an exchange. It is believed that mental energy gets its first assignment with primitive concepts and that it gradually transfers to concepts developed in the child's mind from its parents. Since mental energy has two principal components, the erotic and the thanatotic, and since they are meant to work hand in glove with each other, it is deduced that whatever enters the mind is affected by each of these two elements of mental energy. Since the child's first knowledge of itself is that of its body, it follows that *what it knows* of its body is charged with both the constructive and the destructive emotions in variable quantities, dependent largely upon the training inculcated by those who bring up the child. From the primitive sector of the mind,—in which location it is known as *instinctual energy*,—the child's mental energy passes, therefore, on to the ideas the child develops about its physique. When the energy is lodged in the latter it appears in the form of emotions allied with body-mindedness.

Then, with the growth of character traits, mental energy shifts over to them, strengthening them with both emotional constitu-

ents. Every time the mental energy changes its seat it leaves some of itself behind. From body-mindedness the energy goes to mind-mindedness, which is made up largely of the child's ideas of its *personal* self in contrast to its *physical* self. The combination of the two, including those emanating from the parents, creates what is called the *super-ego* or *inner conscience*, which is the individual's first mental organization having control over his instincts. Because it is the first, and because it is so firmly knit, *the super-ego continues to hold an undisputed, autonomous position for a number of years* and resists every attempt to abridge its powers. However, it normally relinquishes its influences in favor of the developing ego that is, *what the child thinks of himself in virtue of his own judgments.*

We thus see that mental energy is first entirely bound to the primitive side of the infant, the *Id*; then a good share of it moves via the parents to its *super-ego*; thence to its own *ego* by way of its own personal observations. In other words, much of the mental energy returns to the child, from whom, in fact, it had never been divested. It was simply farmed out for training. The schooling of the emotions by the parents is preliminary to that by teachers, playmates and other associates, who help to form an additional mental organization called the *ego-ideal*, that constitutes a *conscious standard* by which the individual is guided. The formation of this conscious standard diverts the individual's mental energy from the parents to others, all still in the service of *ego* development. When the individual finally attains full strength, he is prepared to distribute a quantity of his mental energies to others, to wife and family, if he has such, and thus the cycle of emotional life is completed.

Psychiatry is the study of the emotional cycle in detail, and is occupied, in large part, by the weak or incomplete portions of its structure. *Normal people are a strong unbroken circle; the psychoneurotic individual is a complete but weak circle, while the psychotic patient is only a sector of the circle.*

Anyone making a fairly extensive, but not too deep, survey of his emotional history can verify the foregoing as it appears sub-

sequent to the period of infancy. The facts are there and they are discernible. *One's mental attitude is far more important than the intelligence needed to put them in some understandable sequence.* The earnestness that many people devote to the pursuit of difficult intellectual problems is frequently matched by the indifference they show to themselves. Man's foremost enemy is himself. If we explored ourselves half as much as we try to grasp intellectual topics, the reward would be great indeed.

We are familiar with the fact that time and again we restrain ourselves from carrying out an impulse to do or say something. We ram the desire down into ourselves and feel tense as a result of it. It is almost a daily experience, this shuttling back and forth of a craving or wish. Not infrequently the impulse is exceedingly troublesome, so hounding us that our usual activities suffer considerable interruption, because it forces us to pay greater attention to it than to the things we really must do. This is a simplified reference to the concept of *mental conflict*, which may assume such huge proportions as to engender complete succumbing to a mental disease. The patient vainly struggles to maintain some semblance of equilibrium, but ordinarily such a violent skirmish is won by the inner forces, because they corral the mind's energy. Furthermore, we unwittingly play into the enemy's impulses by forcing him to retreat into a fort—the unconscious—which is impregnable to us, until such time as we have the professional help with which to storm the stronghold. While this may be a figure of speech, it is nevertheless representative of the general action that takes place in the mind and to this the average patient, who has been so beset, can attest.

The individual, that is, his conscious control, has been so weakened by the pursuit of the foe towards the stronghold of the unconscious, that he is at the mercy of the well-entrenched and well-armed enemy. The patient finds himself utterly exposed to shell-fire. The only recourse left is to lie inactive, in a foxhole. That is the hapless predicament into which he has been drawn. What he originally had thought was an alluring bit of strategy turned out to be his undoing.

This situation is spoken of as *repression*. It means that the conscious part of the mind, the ego, has been tempted into conflict by impulses from the unconscious that refuse to be quelled by diplomatic overtures, that is, by reasoning. The pen is not mightier than the sword, not when you are trying to resist an enemy bristling with swords. Our instincts are crude and ruthless; they have no respect for the moral codes by which we try to get along. The craving for the unconditional gratification of their interests is the driving force behind them.

Patients who have lost to such overwhelming forces understand this experience very clearly. To them these are not just words; they are the dreadful truth of the internecine warfare in which they are engaged. Emotions are real. Those who have had the good fortune to disarm the enemy while he was but a threat, while, at the same time, they were strengthening their moral selves without having to deny their instincts rightful expression, those people are apt to be indifferent to the less fortunate or afraid of them, lest they be emotionally infected. *Only the susceptible can be emotionally infected.* The fact that the great majority of people flee from those emotionally disturbed might very well be an indicator of the weakness and insecurity of their own personal organization. If this is true and if we face it squarely, the advantage is in our favor to institute such measures as may serve to strengthen ourselves. It seems, however, that people at large simply close their eyes and sit in a complacent serenity that gives the criminal free play. We see it happen every few years among nations—wars, which, after all, are little more than the massing of those very emotional drives inherent in the individual.

Mental energy is very mobile under normal conditions. When the occasion is suitable its two components (the tender and the tough) can flow out upon the environment relatively freely, either alone or in conjunction with each other. However, to do this, it must obtain freedom from the four principal censors whom it passes by. Assuming that it starts from the instinctual sphere (the *Id*), it must pass the scrutiny of (1) the inner conscience (the *super-ego*), then (2) that of the ego and its close affiliate,

(3) the outer conscience (the *ego-ideal*). Being free to go out into the environment it must now find and be accepted by (4) a recipient to whom it will be welcome. The prerequisites to cover such journey are not at all easy to meet. Indeed, it is rare to encounter an instinctual urge that does not have to be modified to some extent before reaching its goal.

There are all grades of restrictions that can be imposed by any one or all of the four censors. An emotional "problem" arises when the instinctual urge seeking freedom of action is curbed. Under such a condition the individual says he feels "tense," because he has to hold the impulse back. The greater the restraint placed upon the instinct, the greater the tension created by the impulse's energy. It has already been shown how the accumulated energy may crowd itself into the ideas of the individual, inducing mental tension and how it may be forced into organs of the body, appearing as physical tautness which may be so severe as to simulate a physical disease. In each instance, if the tension is long-lasting and more or less completely held in abeyance, the original purpose of the instinctual drive may be obscured, because attention is diverted to the abnormal state of the mind or body. The energy then reaches the environment in the form of nervousness or alleged physical disease. The point to be emphasized is that the energy gains freedom of exit in the form of disguise. Neither the patient nor his friends can see through the symptoms to the cause. In another form of disguise, "peculiar" or morbid ideas espouse the mental tension for presentation to the environment. Such ideas include fears, obsessions and their associated compulsions, misinterpretations, delusions and hallucinations—each of which can act as the scapegoat to convey the energy of the instinct into the wilderness of a mental disorder.

It is possible that one of the instinctual components (for example, love) may be allowed to complete its journey to the end, while the other (hate) is held for deportation, all this depending upon the nature of the censors at the four gate-posts. When this condition (separation or *defusion* of the instincts) prevails, to the individual's misfortune, some grade of nervousness supervenes,

from simple and transient anxiety up to a severe and prolonged psychiatric state.

Certain people have their love component so completely bound up with both their parents, or with one of them, that they cannot love someone else. Whether the love is really lived out with the parents or is surreptitiously carried on in the unconscious sphere makes no essential difference from the standpoint of their inability to fall in love with a possible marital partner. This is not an uncommon way of living; we can all recall one or more such persons. If they live comfortably that way and are not bothersome to others, there should be no interference, psychiatrically or otherwise. However, it is not an easy balance to maintain because *the love for the parents must be more or less rigorously asexual* or trouble will ensue. When filial devotion is acted out upon the living parents, it is less likely that overt sexuality may take place, though a variety of subterfuges just short of intimacy is often seen. *From the point of view of emotional stability, there is great danger of a harmful mental state* when child-parent love takes place in the unconscious sphere, in which the instincts have far more freedom to play upon one or both parents. Unconscious sexuality with a parent is facilitated when in the early years of the child's life there is too close a relationship between the two. The strength of the parental image (the *super-ego*) may remain unimpaired over the subsequent years.

If it is a son, now a grown man, whom we have in mind, one who still lives for his mother, though she died many years ago, we may see him going through life as a bachelor, meeting people cordially, but never getting close to them, not close enough to share personal warmth. *His love is with the image of his mother.* The aggressive element has been taken care of in his constant preoccupation with his career. He becomes a leader in his field. As the years go by he may maintain that status of instinctual distribution. There are pitfalls, though. He has to meet, for instance, one of the crucial turning points in any individual's life, the climacterium, the change of life, the equivalent of the menopause in women. Often this is difficult enough to hurdle from the standpoint of the body

changes concomitant with it, but when the burden of a delicately balanced psychological system is added, the probability of stumbling is high.

Then there is always the probability that work, which in the years when he was climbing to the peak of his efficiency, kept him closely preoccupied, may become "second nature" to him, meaning that he performs it with less need for full application of his energies. Not infrequently we see this person when he is restless and irritable, because he has a lot of freely floating, aggressive energy that is bothering him since it is unattached. He has no recreations to which to turn, so they cannot take up the slack. He becomes crotchety, whimsical, intolerant of inconsequential errors. He tries to delve more heavily into work in order to tie his energies to constructive activities, but nervousness precludes the possibility of sustained effort. He begins to turn the aggressive energy against himself and in so doing he charges himself with inefficiency and blames himself for committing minor errors. The loss of self-esteem passes over into sadness and depression. Now he can but hate himself for the narrowness of his life; he rebukes himself for having been only a son and a businessman.

This is not an uncommon evolution of the aggressive mental energy, when it operates more or less alone out in the field of awareness, with the love or tender element securely attached to the *parental image* in the sphere of the unconscious. For healthy adjustment the two instinctual components should co-exist for each other in connection with adult aims. *It is too dangerous to expect cold love for one's inanimate work constantly to take the place of heart-warming love for living people.*

In situations of this kind we have a clear example of what is called *reaction-formation*, which means that *when an emotional or instinctual component is held in repression in the unconscious, its opposite may prevail in consciousness.* The man in question had a bountiful supply of love which he consistently devoted to external use upon others. Whenever it appeared to him that some of it was pressing for outside activity, he replaced it with a feeling of aloofness and distance, that is, he called upon the aggressive ele-

ment to help him keep the love in the unconscious—attached to his parents and away from others. Sometimes this is also called *reversal-formation*, the idea still being that a conscious attitude may be the opposite of an unconscious impulse.

Reaction-formation is a natural, normal step in character formation, constituting *a bridge between the narcissism of the first few years of life and the altruistic interests of later years*. The child gradually learns that he cannot peacefully keep up his selfishness when he begins to share play with other youngsters, and he learns to respect the wishes of older people. He would prefer to do as he pleases, because his parents encouraged him in that direction and even rewarded him. He, therefore, finds it difficult to understand why his parents, as well as others, are insisting upon changes. They used to beam upon him when he took the spotlight to recite poetry, to draw a picture, to repeat the ABCs, to tumble. They could not get enough of him. Nor could the guests who came to the house. As other children came along, perhaps brothers and sisters, perhaps children of other families, he had to suppress his solo acts until such time as he was called upon to display his skills.

Everyday experience shows how hard it is for the youngster to defer the actions that formerly gave such pleasure. It seems that nature, so to say, recognized the hardship of transition from selfishness to altruism and, therefore, made it as easy as possible by prolonging the period well up into mid-adolescence. It is accomplished at first by suppressing certain thoughts and acts in favor of their opposite. The child is taught to sit by and keep quiet, while another boy of his age is acting a part. He does not want to be a spectator, nor does he want to applaud his rival; he pays no attention to the latter, is preoccupied with himself, often to the chagrin of his parents; he is fidgety to continue with his own personal interests. It is not at all easy to de-narcissize him. This is a very crucial assignment for the parents, whose skill and tolerance are taxed in large measure.

If the parents keep the child to themselves, adoring the infantile and puerile powers and abilities, obviously the process of altruism will be considerably delayed and may develop inadequately. *Undue*

retention of the child's selfishness by the parents often leads to faulty behavior on the part of the child in the years to come. It is just as much a mistake to hurry the change away from narcissism, for it gives the child little time for assimilation. What most parents fail to appreciate is that, having the advantage of centuries of experience, nature allows years for the training of the child towards mature behavior. With little or no experience many parents set themselves up as the foremost authority on the rearing of their child, assuming a supreme position which they might not think of taking in matters of much less importance. Parents should facilitate, not replace, the aims of nature. It is just as possible to mar a personality as it is to spoil a stomach. The big difference is that, when shown, the parent acknowledges his or her part in the stomach-upset and proceeds to make suggested changes, but too frequently resents any hint that his or her handling of the child's emotions might be wrong or incompetent.

At any rate the normal child, properly reared, is gradually, very, very gradually, taught to translate instinctual impulses into socially acceptable behavior. This is done by gently suppressing the impulse and acting as if the imposed substitution were agreeable, which it is not for a long time. *In many children this process of "sacrifice" of one's instincts is long delayed, while in others it is never substantially achieved.* We see many patients in whom the childish selfishness is never relinquished or at best is thinly veiled.

Here is the source of a common misapprehension. When a child grows up to act like one or the other or both of its parents, the tendency is to place this similarity on a hereditary basis. It seems true that personality has its limitations of growth just as body organs have, yet it is also known that a potentially healthy personality or organ can be stunted by conditions after the genes have had a good start. The mind of the child is also often the mirror-image of its parents, as the child sees them.

Some parents quickly stifle any affectionate display in a child, compelling the infant from the start to conceal it and continuing in that attitude through the remaining years. The fundamental reason for this is to be found in the parents' dislike of or hate for the

child for one or more reasons. Without discussing the reasons at the moment, it can be pointed out that *when a child is forced to suppress or repress its primal tendencies, it is almost certain that the child will grow up a mental cripple*. An unloved child may never be able to live freely any more than an overloved one may. The same general principle can be laid down also when the child's aggressive component is given too much or too little play. The personality has to have time and favorable conditions to insure good growth. We easily agree to the necessity of time and conditions for the development of strong muscles, but we act as if only *the personal views of the parents* are the requirements for bringing up a child.

There is one other mental "mechanism" that merits consideration at this juncture. The infant learns by imitation. For the first few years it imitates the parents almost exclusively. Indeed, it is through the process of imitation or *identification*, as it is called psychoanalytically, that the parental code of discipline (the *super-ego*) is engrained in the child's mind. Identification is by no means a static process; on the contrary, it is highly charged with mental energy. It is imperatively necessary to know that *the love possessed by the child seeks to find its complement in the parent*. So, too, *does the child's aggression try to unite with that of the parent's aggression*.

The possible permutations are many. The child may be poor in love, rich in hate or vice versa. The same probabilities hold with each of the parents. Or, any one or each of the three parties may be normal in the use of love and aggression. *The final arrangement among the three determines the character of the child*. This will be illustrated in the chapters to come, yet a few examples may be cited here, and they are not at all uncommon. An infant's love may reach out in full measure only to be rebuffed by the father, but completely reciprocated by the mother. This state of affairs may go on for years, giving rise in the child to a pattern of reaction to males and females that may condition the child for the rest of his days. He (or she) has learned to love women and to be afraid of men. Or, he (or she) may be so trained with a woman's psychology that he (or she) cannot identify himself (or herself)

with men, save from the point of view of hostility. Nor is it difficult to appreciate the type of adult personality emerging from an infancy during which father loved and mother rebuked, or during which neither loved, but only hated, or both were indifferent, turning the child over to an orphanage or some equivalent.

When a child who is a stranger to its parents in the matter of emotional exchanges is brought up by a nursemaid, the child's code of behavior is patterned after that of the nursemaid. Now, the nursemaid's position in life, usually being that of a subordinate, may condition the child to feel more at ease in the presence of one who is inferior to others.

A mother took first serious interest in her boy, when he was sixteen years old. She had always made excellent material provision for him; she could have done as well a few thousand miles away. She was too busy with a career to be close to him. In fact, the immediate reason for her sudden interest in him at the age of sixteen was his association with "lowly" characters with whom he palled in drinking bouts. His conduct was embarrassing to a mother then at the peak of her career. The boy never associated with his social equals "on the avenue," but always went a few blocks away to those whom he knew best, to those with whom he had been brought up by the nursemaid.

When seen by the psychiatrist he was a happy-go-lucky fellow, bragged about the number of times he was thrown out of schools, and the best ones, too, and he took delight in recounting tales of conquest with wealthy girls "only to knock them flat, that's all." It was tragic to see a young man so resentful of the manners of the well-bred. He knew the manners, but they were used by him to "get even." The other language—the slang of the gutter—he knew and liked better. He enjoyed stories such as those relating to the times when he made the rounds of saloons with men of his lowly tastes.

The boy was totally unlike his mother, but that was not surprising, because she had played no emotional part in bringing him up. His parents separated shortly after he had been born, because his mother even then was the wage earner of the family. Indeed, she

created such a feeling of inferiority in her husband that, by mutual agreement, he left her. The boy was promptly given over to the nursemaid, who brought him up according to her psychological leanings, which were the antithesis of the mother's. At least they were real and, therefore, they were his guides for growth.

As a rule, there are no adequate substitutes for parents, because, seemingly, there is an instinctual need to grow up with them, as part of them. When it is known that they are at hand but not available, there is an emotional void every bit as genuine as a physical one. It is said that nature abhors a vacuum. Psychiatrists are all too familiar with that law as it applies to the emotions.

This chapter, then, has shown that *mental energy is a particularly vital force in the lives of human beings.* Quantitatively it can range from very small to very large. In quality there are two great streams of instinctual energy, the one called *erotic* (constructive, tender), the other *thanatotic* (destructive, aggressive), each of which may vary in point of strength. We saw, too, that these manifestations of mental activity are very mobile, flowing, as occasion arises, from one object to another, from the sphere of the conscious to that of the unconscious. *They are the principal factors in the formation of the earliest evidence of conscience in the child,* participating heavily in the construction of the super-ego.

Attention was likewise given to the fact that *the two major emotional (instinctual) streams work best when they are together, that is, fused, and when they are directed outwardly upon socially acceptable situations.*

It was stressed that while really a resultant of several factors, the growth of the child is determined by the commingling of the child's and the parents' instinctual components.

The Role of Organic Factors

Before proceeding to the study of individual diagnostic groupings, we shall consider the fact that, like any body organ, the mind can be unfavorably influenced either by conditions arising within the mind itself or by those coming from outside sources.

For example, heart-action may be weakened because the heart was originally of poor material and is worn out; or heart-action may be hampered when the heart is affected by an infectious disease that settles in it. Yet heart disturbances are not all primarily due to the heart itself, but may be caused by disease elsewhere in the body. An otherwise strong heart may be overtaxed when it has to overcome resistance to pump blood into lungs that are filled with pneumonia, or against kidneys whose filtering system is clogged up.

All organs of the body are so closely interrelated that it seldom happens that only one organ itself goes out of order. Usually the effects of a disease which is more or less strictly confined to one organ is felt in other organs also.

An analogous situation prevails as regards the mind. To the best of our knowledge today, and it seems compatible with reason, *the mind can and does show alterations of organization and function that appear to originate within the mind itself.* In these instances the finest clinical and laboratory examinations fail to reveal any organic changes that can be identified with the mental deviations as their cause. We say that such conditions are *psychogenic* in nature, meaning "originating in the mind."

There is a second large group of mental disorders caused by conditions that proceed from other organs. It appears that very fre-

quently, though not always, disorders of the brain are accompanied by mental variations. It may be said in general that there is almost a direct correlation between the two. The more pronounced the brain disease, the severer the mental changes. The reverse, i.e., brain affected by mental changes, however, is not known to exist. Apparently the brain can convey the most distorted mental material (delusions, hallucinations, etc.) without itself suffering any recognizable damage, but when the brain is out of order there is a more or less concordant interruption of mental functioning. When the latter is the case, that is, brain disease with resulting mental disorder, diagnostically we give preference to the first cause, calling the condition *somatogenic* (i.e., originating in the body).

But the condition of brain disorder due to disease or dysfunction in parts other than the brain must also be taken into account. The sequence may, therefore, primarily be heart disease, which as a second stage causes interference with brain function, say, through a reduced blood supply to it, and in turn there is impairment of mental functions. In each instance, when gauged in terms of symptoms, the damage done to the *mind* depends greatly upon the strength of the mind. *A strongly organized mind*, that is, one that has grown to maturity in full vigor, certainly *will not succumb to a mild disease of the brain or of other organs, whereas a weak one ordinarily does.*

In matters of differential diagnosis, the physician's skill is put to the test in determining which is primary; and for purposes of mapping out treatment, it is essential that the aggregates of mental and of physical symptoms be set apart, because each requires a different mode of treatment.

Care must be exercised also in the understanding of a physical and of a mental disorder which only co-exist, but which are otherwise unrelated. One should be wary of the temptation to correlate the one with the other, unless the facts warrant it. A history of the development of the two conditions will usually clarify matters far better than a review of the possible theories can do. Theories are invaluable, but they can never have the same weight as the actual facts that enter into a situation. At best they should serve as

guides to examinations, not substitutes for them. If the practice of careful history-taking were followed, the probable errors in medicine would undoubtedly be appreciably reduced. Very often *the difference between a good physician and a careless one is to be found in the attention each gives to the search for and the evaluation of the facts relating to the development of an illness.* Experience demonstrates that frequently the total time devoted to a patient is considerably reduced when full information is at hand. This seems to be no less true in the general practice of medicine than in psychiatry. Physicians have unfortunately gotten into the bad habit of short-cuts, particularly through the abuse of more or less exclusive reliance upon laboratory techniques, which in many instances almost do away with the physician.

ORGANIC MENTAL SYNDROME

When an organic disease, for example, hardening of the arteries of the brain, begins to affect brain activity, producing a general impairment of the power of concentration, with relatively easy intellectual fatigue, dizziness following upon quick changes in position of the head, and perhaps headaches, there may be no essential changes in the emotional life of the individual or, if the personality had always been more or less close to the brink of insecurity, there may be a pronounced exaggeration of his natural character traits so intense in some instances as to obscure the physical symptoms. This is particularly apt to be the case when the physical symptoms are mild and slowly growing. The mistake may be made of seeing only the mental symptoms, because they stand out more prominently, whereas *a detailed history* of the evolution of symptoms might very well give clues leading to the origin of the underlying causative factors.

Another feature of distinction in the interaction of organic disease and mental aberration rests in the fact that *a certain organic disease* in a given tissue of various individuals *induces a comparatively uniform set of physical signs and symptoms*, while the effect of the same physical disease upon the mental organization of various individuals induces alterations that reflect the type of one's

personality. For example, a tumor of the brain acting upon a "scary" individual may cause great intensification of the fear; it may give rise to exaggeration of an obsessional tendency, if that was characteristic of the person before the brain tumor began to cause trouble. The same tumor in the same locality might throw a cycloid person off balance, giving rise to a manic-depressive condition, or it might set going a group of schizophrenic symptoms in an individual so disposed. In other words, there is no known region in the brain or in any other part of the body from which any uniform set of mental symptoms originates. Insofar as we know at present, if a standard stimulus can cause mental abnormality, it provokes a *mental response that is in keeping with the organization of the personality*. If the person has for years bordered on forming delusions and hallucinations, any adequate stimulus, mental or physical, will bring them out. However, it is not in accordance with the facts to see the cause only in the mental or physical stimulus, but also *in the susceptibility of the mind*, unless, of course, the stimulus is so severe as to lay bare the innermost impulses of the mind.

When the personality is disrupted by a slowly growing brain disease, mental changes are intermixed with organic symptoms, otherwise the general trend of regression is approximately the same as in the absence of organic factors. Often this admixture breaks the smooth continuity of the mental trend, which is then observed in fragments, the sizes of which depend in large measure upon the extent of intellectual impairment. Studies on patients showing the earliest manifestations of both mental and brain decline prove that the patients first relinquish social customs, recreations, and consorting with friends. Even if incapable of carrying on their business career with usual efficiency, they try to maintain it as long as they can.

When the personality is strong, the decline in mental functions may not go much beyond social and professional relations. If further regression takes place, it usually follows one or the other of two courses. (1) The simplest type of mental regression steadily takes the patient step by step back *through the path of conscious*

experiences in life. Assuming that he is forty-five years old and married, this means that he goes back to the earlier years of his maturity, then to the premarital years, adolescence, late childhood, early childhood and finally infancy. *In this course of regression the unconscious remains essentially undisturbed.* The name given to this form of regression is *simple dementia*.

(2) In the second type of regression *the unconscious participates to a great extent, its crude instinctual impulses often being overtly lived out.* Thus, if, before the onset of the brain disease, the patient had leaned in the direction of a psychoneurosis, he will have regressive psychoneurotic symptoms when the disease upsets mental functioning. An analogous situation prevails, if the patient had formerly bordered on or showed a susceptibility for one of the psychoses. Therefore, there is an intermingling of physical symptoms with a manic or a depressive reaction—if the predisposition was towards a manic-depressive disorder; or with one of the schizophrenic subdivisions—if the susceptibility was in that direction.

In any organic brain disease with a mental disturbance *three major conditions prevail, any one of which may take a predominant role.* (a) There are the *signs and symptoms of the organic disease*, such as headache, dizziness, vomiting, visual alterations, disturbances in gait and posture, speech defects, complete or partial paralysis of muscle groups, etc. The neurological symptoms are the same as if there were no mental disorder.

(b) *There is impairment*, and this, too, is neurological, *in intellectual functions*, including loss or modification of appreciation of or orientation in regard to three relations—relations of time, space and person. There are memory defects. *The memories to disappear first are ordinarily those most recently acquired*, the patient forgetting where he placed an article a few minutes earlier, forgetting what has just been said to him or something that he was reading at the moment. Later, memory declines with respect to *less recent happenings*, such as those of the past few weeks or months. When the deterioration is extensive, it reaches back into the earlier years of life, *eradicating memories of long standing.* Because of the intellectual loss or inadequacy, that is, because past

experiences no longer guide him in his daily activities, the power of *judgment* is proportionately affected. With the wiping out of past knowledge, the patient moves about with wishes as his only guides. Thus, he may go out quite inadequately, improperly, or "indecently" dressed. There may be the wish, devoid of judgment, to visit a relative. Though it is midnight and the temperature is below zero, and the relative lives a thousand miles away or perhaps has been dead for some time, the patient leaves the house in his pyjamas, and, completely oblivious of anything in the environment, he wanders off in obedience to the wish alone.

(c) At least, from one point of view, nature has provided him with protection, since it causes him to lose partial or full appreciation that he is a sick man. We then say *he has lost insight*. Without conscious control, *the lurking wishes held back for many long years are given full play*. The old impulse to become a merchant prince blooms in the mind of the small dealer in merchandise. In his delirium he controls the market in his field, giving and receiving orders that run into millions and billions of dollars. Then he branches out into other fields, gaining full possession of each, until eventually he is omnipotent in the field of business. If his interests lay formerly in one of the professions, he becomes omnipotent in that profession. In the final stage, bedridden, he still directs his miraculous activities, now through the only facility left to him, the wish. It can be seen that in his progressive intellectual decay, the mind has come to his rescue, replacing the untold losses with extravagant fancies.

The poor housewife, the drudge of years, comes—in her wish life—to be the head of a magnificent household and the social arbiter of her period. Liveried help stand around waiting to do her bidding. She is a princess or a queen and she carries on long conversations with her royal husband as Queen Hortense did. *Of wishful thinking* there are any number of variations contingent upon the innermost impulses. *They serve the purpose of filling the void created by the losses due to organic disease.*

Another type of overcompensatory thinking is known as *con-fabulation* and refers to the process of replacing memory loss by

reality that is not true for the occasion. A patient bedridden for six months recounts the happy events of yesterday on the alleged occasion of a visit to his sister's home. He gives complete details, borrowed from some former visit or from his imagination—to fill the empty vessel of his memory. The main difference between confabulation and the bizarre wish is the realism of the former; the patient describes what actually could have happened, though it did not.

Still another distinguishing feature of what is known as the *organic mental syndrome* (a syndrome is the aggregate of concurrent symptoms) is made up of the more pronounced and vivid mental and emotional symptoms coming from the realm of the unconscious, appearing as delusions, hallucinations, obsessions and other regressive phenomena.

The same general situation holds true whether the mind is upset through disease in the brain itself or in any distant part of the body, provided it causes physical alterations in the brain. This is not at all to say that the prerequisite for a mental disorder is a brain disturbance, for that is certainly not a known necessity. We are simply calling attention to *one* set of factors that can precipitate a mental disorder. It must also be remembered that there are brain diseases which do not lead to a formal psychiatric state, even though memory, orientation and other physical activities be relatively severely affected.

The discussion of these several possibilities does not mean that anything is likely, that there is no rule of thumb to be guided by, for that is not the situation; the points of decisive importance are twofold: the strength of the personality (the mind) and that of the physical disease.

Years ago, when they moved over from the ancient priests and priest-physicians to the field of medicine proper, psychiatric problems were investigated and taken care of by the general practitioner of the time. As specialization began to differentiate in the general medical realm, it appeared reasonable to affiliate psychiatry with neurology on what may be a true supposition, that both are substantially related to the same anatomical areas. This was the era

of major interests in organic diseases and the alliance proved fruitful in many ways, chiefly because the borderline between neurology and psychiatry was as yet unstaked. Intensive surveys through the years helped to demarcate the boundary, so that today it is fairly well-known what belongs to each field. There are still differences of opinion as to where the line should be drawn at certain sectors, or whether it should be marked at all; but there are certain areas that are wholly included on the one or the other side of the line without overlapping. In general it might be stated that (1) *neurology is the study of the nerves and nervous tissue*, that is of organic tissue belonging to the brain and spinal cord; (2) *psychiatry is the study of the mind, of the mental organization*, including the emotions, impulses, experiences and ideas.

During the past half century neurology and psychiatry have lost much of their former mutual trespassing, due to the fact that the vast majority of mental disorders cannot be understood in terms of neurology. Whereas in former years textbooks on the subjects gave equal attention to both under the same cover, often, indeed, combining the symptoms of both in the same paragraph, the tendency of the past several decades has been to present each subject in a separate treatise.

However, *psychiatry has not grown away from organic medicine*. On the contrary, it is closely affiliated with it. It still operates in close unison with neurology at given points of investigation, but it works just as intimately with biochemistry, cardiology, gastro-enterology, internal medicine, surgery, genetics and psychology, in fact, with all the specialities. This is as it should be, since the human being is a psychobiological entity and psychiatry is a division of medicine with special emphasis on features of the mind.

In view of the high specialization of neurology and psychiatry, the student of one of these specialities is usually less well-versed in the other. Accordingly this being a treatise on psychiatry, no effort is made to discuss the finer details of neurology or of any of the other specialities claiming close attention. In this connection it seems worth while to realize that today there is a higher per-

centage of mental patients with minds preoccupied in stomach disorders than in neurological disturbances. *Neuropsychiatry is a man-made combination, but gastropsychiatry is nature-made.* It is reasonable to expect that other combinations may appear, particularly chemo-psychiatry. If history repeats itself, psychiatry will join forces with any human endeavor, in a trial union as long as the relationship gives fair promise of enlightenment. It has gained much from these other fields in negative results, because thus far there has been no evidence that the ills of the general run of mental patients are due to any organic causative factors.

Diseases and injuries may set in motion a mental disorder that otherwise might well have remained dormant for the rest of the patient's natural life. When the disease or injury is relatively extensive, there is always some interference with the emotions of the patient. Yet, variability is so great that one cannot predict with any certainty the sequence of events most likely to follow a severe disease or injury. One patient may not show much mental disturbance in the face of severe organic changes, but may have pronounced intellectual and other physical impairment. Another patient, with about the same location and degree of tissue-damage may show serious symptoms in each of three spheres—mind, brain, and other body-organs. Any combination is possible and likely.

Some individuals who have always been on the borderline of a mental disorder may grow much better mentally when an organic disease or injury comes upon them. Apparently their emotions and attention are then drawn away from their mental symptoms and directed to the site of the disease or injury, only to return to the mental sphere, when the organic condition clears up. Other borderline individuals add their mental symptoms to the organic state, producing a combination of psychosomatic complaints out of all proportion to the usual sequence of events relating to the organic disease itself. It is a common observation that the person diagnosed as having a *traumatic neurosis* is one who experiences a relatively inconsequential injury. *A traumatic neurosis has been defined as a mental disorder of mental origin.* It may or may not be complicated by any structural changes in the nervous system or elsewhere. If

the mental picture resembles a psychoneurosis, it usually differs in mental content from the nontraumatic psychoneuroses, in that the conscious ego is more vividly disordered than are the unconscious parts of the mind. For that reason many authorities refer to a traumatic neurosis as an *ego-neurosis*. The individual who is not making much headway in life, who feels that the responsibilities of working and perhaps maintaining a family are too burdensome to him, may convert his feelings of inferiority into physical methods of expression. If his employer is covered by compensation insurance, this individual, already on the brink of a neurosis, may claim compensation whether his injury is severe or inconsequential. It is then said that he has a *compensation neurosis*. If his tendency was in the direction of a psychosis, he may develop a psychosis, though for the record it is called a compensation neurosis. Psychotherapy is often ineffectual in these instances, particularly if the patient, on the verge of quitting work altogether, knows that he can quit work and draw pay. No matter how meager the compensation may be, it is still more than he thought he would be able to make. Furthermore, he is spared the so-called stigma of mental disorder, because the law has confirmed the role of the injury.

In the succeeding chapters, questions of identifying the types of personality that are the more likely candidates of mental deviation will be explored, principally for purposes of recommending measures of treatment.

(1) Stress will be placed upon treatment-measures that can profitably be used by parents and others with whom the individual associates, for it is felt that the *proper management* of the individual *long before there is any trace of morbid symptoms* is far to be preferred to every sort of treatment administered during the stage of symptoms.

(2) Secondly, it is expected that the recommendations may be useful to the physician, not necessarily a specialist in psychiatry, because often he is today the first called in to examine and treat the patient. The physician may not care to treat him, but if he does, there is no excuse for failing to conduct a reliable examina-

tion into the mental factors that may be the primary reason of the patient's complaints.

(3) Third, emphasis is placed upon a description of mental disorders in their *earliest* and subsequent manifestation, with observations on their outcome and response to current modes of psychiatric treatment.

Perhaps the psychophysical changes concomitant with pregnancy are of no less, though of different, significance to the human being than are those associated with puberty and the climacterium. The prospects of parenthood, as well as parenthood itself, play an important role in the life of people. Long before courtship or marriage, most individuals have their minds made up as to whether they want children, and, if they do, how many they want, and of what sex. The normal person is more or less clear about these topics and prepares for courtship, marriage and parenthood, though by no means does he or she move into and through these phases without deep feelings. Allowed a fairly wide range of reactions to each of these three new social institutions of living, the normal person does not deviate far enough from healthy mental reactions to be considered abnormal. They throw his or her emotional system off stride for a while, but not off balance.

The factors that make for successful parenthood are laid down in the parents, often long before the parents ever meet each other. Their own instincts and the way the instincts have been brought up by parental training help greatly to determine how the individual passes from infancy to childhood, to adolescence, to courtship, to marriage, to parenthood, to the climacterium, to the stage between the climacterium and senescence, then to senescence. Those who are poorly prepared emotionally certainly face many pitfalls en route.

Parenthood is only one of the difficult stages, the one to which we are giving immediate attention. There are no specific mental reactions characteristic of any one of the many stages through which man passes. There is no such thing as an adolescent psychiatric disorder or a courtship or a marriage or a parenthood mental disorder. Factors connected with these phases of living can, how-

ever, precipitate an abnormal mental condition in an individual susceptible to a psychiatric state and *what they precipitate is something already in the individual's mental make-up*. Nothing new is produced, but what previously may have been dormant may become active and troublesome.

The mind of a pregnant woman may be unfavorably influenced by one or more of four basic factors.

1. *An individual, potentially or actively psychoneurotic, may not be able to adapt himself or herself to, let us say, prospective parenthood*. Either the wife, who is pregnant, or the husband who anticipates the coming of the infant, or both, may have their unconscious complexes so stirred up by the prospective event that they lose control of their complexes. The potential psychoneurosis may then break out into the open or the already overt psychoneurosis may become exaggerated.

The same sequence of events may be observed among those who are potentially or actively psychotic. In other words, there is no such thing as a psychiatric pregnancy-syndrome but a psychiatric condition may arise during the state of pregnancy, aided and abetted by the particular psychology of the person to whom the pregnancy is of vital importance, be it wife, husband, child, parents, or in-laws.

Similarly, there is no such thing as a common mental disorder on the part of the parents following the birth of a child, but rather of a mental disorder specific for the given individual. It is a throw-back to obsolete classification to speak of a *postpartum psychosis*, as if there were a psychiatric syndrome common to all who fall ill mentally during the postpartum period. Moreover, the term *postpartum psychosis* (after giving birth) was coined at a time when psychiatric classification was largely restricted to the psychoses. It has been known now for a long time that, from the standpoint of the mind, one of five states may be observed before, during, or after pregnancy—a) normality, b) character neurosis, c) psychoneurosis, d) psychosis, e) psychopathic personality. Postpartum simply tells *when, and in relationship to what precipitating event*.

2. *The state of pregnancy may disturb the proper functioning of organs of the body.* It may throw too great a burden upon a heart that already has a narrow threshold of safety. The heart and other organs may not be able to carry the extra load. Under such circumstances there are physical signs and symptoms, usually commensurate with the degree of impaired functioning of the organ or organs involved. How the patient reacts mentally to such physical troubles is in part at least due to the stability of the mental organization prior to the onset of the physical disability. A disorder, impairing cerebral or brain activity, gives rise to the *organic mental syndrome*.

3. *When an infectious disease is superimposed upon pregnancy, the patient may show the symptoms of the organic mental syndrome.* Among individuals mentally sound before the onset of infectious disease, the outcome of the mental disorder generally parallels the outcome of the physical disorder. When the margin of mental safety is narrow, the infectious disease may precipitate a mental disorder, which may or may not disappear when the infectious disease is cured. The mental disorder may continue for weeks, months, years, depending upon the strength of the personality as it was prior to the onset of the disease.

There is still another point to be considered. The infectious disease may be cured, but not until it has left irreparable damage to the tissues of the body. What damage remains, may or may not influence the personality of the patient. Its importance rests in its extent and location.

4. *External circumstances may upset the pregnant woman's mental equilibrium.* They, too, generally act as precipitating, but not originating causes. Such external conditions are ordinarily those disturbing the emotional life of the patient. They usually come under the heading of loss of a loved one. Again, the prognosis commonly depends on the patient's mental strength as it existed before the external condition had appeared.

All that has been written in this chapter on the influence of organic factors upon the organization and functioning of the mind may be summed up as follows:

1. Permanent, severe organic disease, particularly of the brain, may and usually does affect the mind.

2. The earlier in the life of the individual the organic damage occurs, the greater the impairment of the mind.

3. Ordinarily a sound and mature mind, grown to adulthood, is able to sustain itself as such in the face of a severe, though transitory, physical disorder.

4. A severe, though transitory, physical disorder may temporarily disrupt mental functions in an individual who was mentally sound before the physical disorder appeared.

5. A weak mind may be made weaker by an organic disorder. The weaker the mind is prior to the onset of a physical disease, the more likely will it suffer when a physical disease supervenes.

6. A weak mind may succumb to a mild physical disorder, including the physiological changes accompanying puberty, pregnancy, the climacterium, and the early manifestations of senescence.

Anxiety

In the early years of modern psychiatry attention had to be given first to a description and classification of mental disorders. This study and separation of individual types of disorders was in itself an arduous task, taking years to lay down a commonly accepted arrangement. Psychiatrists reached the peak of what was called *descriptive psychiatry* with the monumental studies by Kraepelin. It was a period devoted to sorting the symptoms into separate groups. This trend of classification converged principally upon the severer, hospitalized groups of patients—those with a psychosis. Meanwhile, some progress was being made in the classification of the less severe mental states, the psychoneuroses. In general it may be said that there is a sounder classification of the psychoses than of the psychoneuroses, perhaps, in the main, because psychiatrists in hospitals are still clinging too closely to the symptoms; they are still classifying mental disorders, stressing diagnosis at the expense of treatment.

On the other hand, Freud entered the field of psychiatry from a very different point of view; he wanted to know *what caused the symptoms, and what could be done to influence the causes*. Hence psychoanalysis grew up in a treatment atmosphere. As a generality it may be said that descriptive psychiatry of the psychoses was nearly as remiss in matters of causes as psychoanalysis was surprisingly and uniformly successful in the orderly, scientific arrangement of symptoms into entities. We seem now to be in the stage in which these faults are being remedied and treatment is the keynote.

Like all other medical diseases or disorders, mental symptoms

do not stand out with razor-edged keenness. The human being is a correlation of many body systems. One of them may be primarily involved, while at the same time producing symptoms also from associated systems. It is this variability that calls for sharp diagnostic and therapeutic acumen.

For example, in a patient with anxiety hysteria, the outstanding difficulty is anxiety, yet that is but the first presenting symptom. Further investigation may well show that the anxiety has also attached itself to one or more organs of the body producing a form of conversion hysteria. Then, too, there may be a tendency to blame others for one's illness, and that leads the physician to wonder whether the projection of the patient's troubles onto others may not have a schizophrenic basis. Sometimes also the course of anxiety hysteria resembles that of a manic-depressive psychosis, though on closer examination the distinction from it usually, but not always, becomes clear. In spite of these accessories the nuclear element, anxiety, issuing from an hysterical type of individual remains the dominant theme.

Perhaps it is not surprising that these extra symptoms come in from time to time, because the psychoneuroses, occupying a position between mental soundness and the psychoses, spontaneously swing across the domain of health and across that of the psychoses, without remaining long over each. Their widest range is chiefly confined within their own diagnostic category.

CAUSES OF ANXIETY

1. *In all manifestations of mental turmoil, from the mildest to the most severe, anxiety is a common factor, varying in strength from one person to another. It does not appear to have any unusual relationship with the type of personality (introvert, extravert or ambivert), in the well-balanced individual. Abnormal anxiety is a danger signal, warning that all is by no means well in the individual's unconscious, inner life. It is a symptom, the equivalent of an ache or pain that signalizes hidden trouble. The mind has its own special kinds of signals of distress, anxiety being foremost among them.*

A practical measurement of anxiety is possible within a given range for anyone who takes the time to measure it. However, first we should know what to look for. *Anxiety is a state of distress. Literally and freely it means a state which "throttles, chokes, causes mental pain." It is intense apprehension associated with thoughts of danger.* According to Freud it acts as a "warning of danger." Ordinarily parents can tell moderately well whether the anxiety is normal or abnormal. The uneasiness related by the child to environmental conditions that reasonably call for care and withdrawal is within average range of normality. Insecurity in space with danger of falling, the fear of sharp instruments or of overheated objects or of moving vehicles are simple examples of reasonable concern, though they call for closer inspection, if they create anxiety that leaves the child limp.

If the latter is the case, the parents should first look to themselves to see whether they are implanting anxiety in the child. It may e.g., represent one of father's own complexes, which he is reluctant to admit he possesses. He may be so accustomed to rationalizing his own anxiety that he believes it to be evidence of good judgment on his part. He can quote from insurance statistics to show that many accidents take place on stairs. Therefore, he goes to unusual lengths to protect his child from falling downstairs. A gate is erected at the head of the steps. That is good sense. But the incessant warning is not, for the fright of the parent is transmitted to the child, who is afraid of the gate, too, for father (or mother) has scared the child into keeping away from it. They should let the gate speak for itself.

However, it is the danger unseen by the eyes that gives rise to greatest trouble. Mother hammers into the child the dreadful effects of infection, describing with horror how children die from it. About the only part of her story that registers in the little mind is the dread of dying, supplemented by mother's unbearable sadness, because the child is gone forever. The emotion written in all her actions is carbon-copied on the child. Indeed, the carbon copy in the child may become clearer-cut than the original. Mother's anxiety is surely morbid and can be traced to the deeply rooted

and therefore to her unknown *impulse towards the child's death*. This is by no means an unusual example of the starting point of an anxiety state of great intensity. The lives of some children are overwhelmed with such dread.

At the instigation of her brothers and sisters, but certainly greatly against her own will, a young woman married out of obedience to their urging. She preferred to live with her brothers and sisters who were married, and towards whom she took the position, sometimes as a child, but more often as a wife in their households. She was overconscientious, strictly puritanical, and straight-laced. She was called "the second wife" by the men of the household, a title to which she readily assented, with the tacit understanding that her services were limited.

She later explained to the psychiatrist that she married out of the sense of duty to her brothers and sisters. They asked her to marry and she did. The fiancé's proposal was an accessory after the fact. She pretended love to her husband, though for a long time she knew she hated him. She hated herself for hating him and for being so ungrateful, as she thought, to her brothers and sisters. With time she drove the hatred out of her sight, but it only went out of sight, not out of mind. It rankled in her unconscious and gave rise to spells of depression and anxiety, which by great effort she dispelled by being overnice to everybody. All who knew her recognized that her subserviousness was a weakness; it did not "ring true." One of her brothers called it a "cover-up."

When she became pregnant, she was extremely meticulous about her health and read extensively on matters of maternity. She placed so much reliance on books that one could wonder whether she or the books were going to have the baby. Underneath it all, it was obvious that she did not want the child and her total faith in books was but a subtle way of indicating her repudiation. Insofar as it was possible for her to do so, she looked upon her pregnancy as an objective phenomenon. She amazed her friends, who wondered how such a refined girl could speak so frankly, so objectively about the very personal things of pregnancy.

By the time she was ready to be delivered of the baby she was

almost completely detached from it emotionally. She sensed the detachment and was hurt by it. Then she started to undo the harm, as she surmised, by building up an artificial love for the child. No baby ever received such undivided love and attention, but it was love and attention born of anxiety. As the anxiety grew, there were frantic efforts on her part to cover it over with greater and greater manifestations of love. Finally the anxiety conquered her and she could no longer take care of her baby. Now, she was sure she would make mistakes, perhaps in preparing the baby's formula, perhaps in improperly dressing the baby; perhaps she might drop and kill the baby. Anxiety was the warning and the safeguard. It saved the baby, which in the first instance was unwanted by her.

She was first seen by the psychiatrist, when her son was eleven years old. Over the intervening years, after she "recovered" from an anxiety attack, she gradually built up a pretense of love, care and attention that seemed to make her and her son inseparable. She brought him up with the best of book knowledge and was proud of the authors from whom she could quote. She failed to see, however, that she never quoted herself. She was not responsible for bringing him up; the books were.

Usually such a way of living and "loving" is dangerous. It turned out to be so with her. She developed intense headaches, for which she received all manner of medicines to no avail. She came actually to know that she feared she would kill her son. She was afraid to be in his presence, lest she push him out of the window or in the path of a moving vehicle. She was horrified by the impulse; she could not understand why she, who loved her son so "magnificently," was obsessed by such an evil thought.

As happens not infrequently with such patients, her anxiety finally connected itself with the impulse to kill her son. Eventually under psychoanalytic treatment, she came to understand why she had such an obsession. The reasons were rooted in a succession of psychological conditions. She could not love the child; she could only hate him, because she should never have had a child by her husband, whom she had never regarded as a husband. Indeed a full survey of her married life provided scores of

facts to make it clear to her that her role in married life was that of a daughter, while her "husband" was "just like a father to me." To her unconscious, she had committed an unpardonable sin. "I married the equal of my father and I was punished for it," was her final evaluation of married life to her. The treatment went further, covered her early life with her parents and her later life with her brothers and sisters. She was able to free her unconscious from its "unholy attachments," as she expressed it. She made a complete recovery.

Her son, too, had to be treated, for he had the unwholesome psychology that love could not exist without anxiety. That was all he knew, for that was all he had experienced. It was not love as we commonly understand it—it was improper attachment of mother and son, founded upon the need to protect son against disease, injury, and death. Among neurotic individuals, love has its own peculiar methods of expression. In this instance, love and death were inseparable concepts. It was as if mother said she could come to love her child only if he were dead. Is this very different from the parent who actually kills his or her children, because the children are doted upon and loved too much by the parent? Newspapers cite a parent to that effect.

Fortunately the mother's neurosis saved the child from what possibly could have been a worse fate. Partly due to her own recovery and subsequent natural attitude towards him, and partly due to the psychotherapy he received from the psychiatrist, he, too, gained emotional soundness.

Dread created in the child may be related to one or more of hundreds of topics. A twenty-four-year-old patient sought treatment from a psychiatrist, because repeated examinations of her heart by a number of specialists failed to reveal any heart disease. As a matter of fact the patient's principal complaint had nothing to do directly with her heart, but she never said anything about it to any of the physicians nor did they ever ask about it. Anxiety was intense and it stood out prominently whenever she was examined, yet not one of the doctors ever thought of looking for the cause elsewhere than in the heart.

Investigation revealed that the increased heart beat occurred only under special circumstances, and that it was entirely secondary to anxiety and resulted from the comments of her closest friends to the effect that she "looked terribly sick, deathly sick." Further inquiry revealed the information that the patient formed friendships solely with women who dominated her and to whose remarks she gave unlimited faith. She got along best with them when they ordered her to do this or that. It seemed like an odd situation that she loved best when most hurt. Moreover, she had developed a subtle technique—which she herself did not recognize—of drawing out comments on health from these aggressive friends. It became obvious from dozens of examples that she discounted remarks which reflected upon her good health—those never made her "feel good"—but she deviously elicited from those "dearest" to her that she was on the verge of imminent collapse and perhaps death. The woman with whom she spent a great deal of time was a verbal sadist who documented with authoritative quotations her prognosis of the outcome of the patient's ill-health.

Anxiety then sapped the patient's strength to the point that she could hardly walk to the street for a taxicab. Often she had to be supported in standing and in getting into the cab to be rushed to her physician. She hurried to his office once or twice a week for seven months. Again she was an unwitting conspirator to the physician's diagnosis that her heart was about to give out. He was encouraged to listen and listen to the heart with his stethoscope, which he usually did for about a half hour. With her gullibility, the time he spent at the heart was in itself thoroughly convincing to her, and if any further evidence was needed it was provided by his bewildering facial expression. There is a name for this role of a physician—*iatrogeny*,—meaning the inducement of a psychiatric condition by a physician. In this instance the physician did not incite the disorder but he did lend unqualified support to her conviction.

That he should have examined the heart as his first move is quite right. He also conducted other physical tests that gave no clue to him. But peculiarly enough during all the time she was under his

care, he did not find out that she was giving professional dancing lessons, an occupation that is hardly possible for one with a badly damaged heart.

On psychiatric examination, the cause of her heart complaints was found to be connected with women, and then it led back to her own home and to her own mother, who had brought up the child in an atmosphere of utter dread. To those who are unfamiliar with and inexperienced in these matters, it may sound unreal to know that mother was addicted to the creation of scenes of death. The unreality is heightened by the fact that only a few close relatives knew of the peculiarities of the household. To all others this was a fine family, closely-knit and of good citizenry, a reputation that was considerably enhanced by frequent visits of the clergyman. The family knew why the clergyman was called—to administer the last rites to the dying patient, who, of course, was dying only in the mind of the mother and of the child itself, who was too young to know that it was not so.

On numerous occasions, whenever mother thought that the child looked sick or when the child gave evidence of indisposition, she was immediately put to bed, the shades were drawn, candles lighted and prayers offered, prayers that spoke of the humility with which they gladly accepted His wisdom and judgment in taking the child to Himself. Only in these death scenes were there exchanges of "love" between mother and child—acts of kindness never took place under other circumstances.

It might be assumed that as the child grew older and learned to sense the meaning of the ritual, she might outgrow its horror and anxiety. But, *intelligence per se does not fertilize the emotions*. As she grew up she learned how to cover the dramatization of death to a fair extent, though at home it continued to be enacted literally. In late adolescence, she began to gain a vicarious outlet for it through women who sympathized with her weakness. Later she found those who were almost as positive as her mother that death was impending.

She was a patient with clear-cut anxiety that had direct continuity with her mother. *When anxiety or other psychiatric symp-*

toms are implanted in the mind by outside sources, in most instances, the response to psychotherapy is more favorable than it is when the anxiety comes almost exclusively from the deep unconscious part of the patient's mind, or when it is the result of a combination of the two. Since there is almost always another person involved, the procedure of preference is to treat first the part of anxiety connected with that person.

The best treatment, of course, is prevention and public education is the foremost method of producing widespread results. In this particular instance, through the ministry and the medical profession, both of which had access to the home of the patient when she was tiny, steps could have been taken that might well have led to the prevention or amelioration of the trouble. Experience in other similar situations shows that a great deal can be done to make life more comfortable for families who are so beset.

The more we see disorders of this type, the less we are inclined to the idea that people "enjoy ill-health." They do not enjoy it. They are entrapped and they try to get out of their misery with the only means known or available to them. Too frequently the "choice" of means of escaping, which is by no means a conscious matter, is as abnormal and distressing as the abnormality whence it arises.

Anxiety is a *symptom*. To be sure it brings great distress, as any symptom may, but it is not the cause of it. The psychiatrist looks for the cause of the anxiety, as the specialist in organic medicine seeks the cause of pain in the chest or elsewhere. *The cause of anxiety is commonly found in the unconscious part of the patient's mind and is usually the result of unconscious yearnings striving to get up into consciousness. The longings are held in place, that is, in the unconscious, chiefly by the patient's inner conscience or super-ego. The mental process by which unconscious complexes are held in abeyance is known as repression.*

Repression serves the function of restraining in the sphere of the unconscious two general groups of experiences.

(1) It checks *primitive* drives, such as those connected with castration, rebirth, omnipotence, cosmic identification, etc. To denote this function, psychoanalysts use the term *primal repression*,

meaning that the primitive, racial impulses are held in check at their original source almost from the date of the infant's birth.

Anxiety is frequently a symptom of warning that the patient's primordial impulses are so powerful that they are on the verge of breaking the bonds of their unconsciousness and rushing into the field of consciousness. Patients often sense that something within them is about to break out; they are terrified by the overwhelming, impending forces. One of our patients was so horrified that he was completely limp and helpless, especially when he got a glimpse of the "enemy" from within. He was barely able to speak, but he said that he was being compelled to believe that he was going to be again an embryo in his mother, that he was going to be reborn, after which he would be eternal, universally omnipotent, and God. This is a clear example of the failure of the repressive forces to keep primitive impulses in the unconscious where they normally belong.

(2) The second function of repression is to keep in the unconscious what has been put in its care by consciousness. The experiences of infancy, for example, must gradually give way to those of childhood. The infantile longings, such as those related to the Oedipus or Electra complex, are sent to the realm of the unconscious for the express purpose of holding them there, by whatever force may be necessary. This function of repression is known as *after-expulsion* to indicate that the complex is expelled *after it has been in the field of awareness*.

In the first instance, primitive impulses are restrained at their source, while, in the second, personal experiences are discarded and held in the unconscious. It may be said as a generality that a psychoneurotic patient is bothered by attempts of the *personal* experiences to *regain* consciousness. Psychoanalysts refer to this as a *return of the repressed*. The threatened return is heralded by an alarm felt as anxiety. Anxiety may appear in one or more of several forms.

(1) It may appear as "free-floating" anxiety, by which is meant that the anxiety seems to be diffused somewhat uniformly through the mind and body so afflicted. The patient claims that he (or she) cannot think clearly, memory is hazy, concentration is impaired;

he feels weak and faint, the pulse rate increases, perspiration may be profuse, pupils may be enlarged. This state of "free-floating" anxiety, called a *daymare*, is said to be created by the process known as *isolation*, a mental mechanism by which *the energy of a conflict leaves the conflict and stands off by itself, isolated*.

Divested of its energy, the unconscious complex may so thoroughly lose its force that it exists in the unconscious as a "dead" issue, being inactive and uninfluential. *The mental process by which an unconscious complex is shorn of its energy is known as "undoing."* It is believed that this process is responsible for amnesia of mental origin.

(2) The anxiety may be diverted to one or more organs of the body, appearing then to the patient in the disguise of a physical disease or disorder. This *displacement* of anxiety upon one or more organs of the body is called *conversion*, which implies *the turning of a mental conflict into physical manifestations*. Conversion does not bring about relief from anxiety, but it does cloak the nature of the real and original trouble.

(3) Anxiety may take still another direction. Among patients who are inclined to *project* their difficulties upon others, it is not uncommon to learn that an unconscious complex, say, homosexuality, is ascribed by the patient to other people, usually of the same sex as the patient. Before this process of *projection* is employed, as a rule the patient had already suffered for a long time from anxiety, which signalized the advent of trouble. The mounting of the anxiety is in this instance an indication that the latent homosexuality is at the threshold of consciousness. In a panic to cast aside the anxiety of the homosexuality, those who are accustomed to blaming others may throw the anxiety in the *direction* of others. The patients may not and usually do not realize the homosexuality in the situation. What they do know and feel is the great anxiety that others induce in them.

4. Anxiety may attach itself to fear; however, usually not fear of the complex in the unconscious, but of something environmental or at least something that the patient usually does not know to be related to the unconscious complex. This may be fear of some

organic disease, or of open or closed places, of heights, etc. The nature of these fears is discussed in the chapter on fears, but here we want to refer to another mental mechanism or process. *When the energy of an unconscious complex is crammed into a symptom, such as fear, the process is called condensation.*

Taking homosexuality again as an example, we often treat patients who so fear members of their own sex that they shudder even to think of them. The patients tremble and, perhaps, perspire profusely when they have to speak to people of their own sex.

5. Anxiety may be attached to dreams, thus creating nightmares. As a rule, the nightmarish patient knows only the overt part of the dream and not its *hidden* meaning. Thus he is protected, by his unconscious, from knowing the real cause of his anxiety.

In this instance is an example of another mental mechanism called *dreaming*, which is generally a process of symbolization conducted in the unconscious while the individual is asleep. The psychoanalytic method (i.e., free association) of uncovering the latent meaning of the dream is in no way different from the method of treating symbolization (fear, obsession, compulsion, conversion, delusion, hallucination, etc.) that shows up in the waking state.

It appears that, other things being somewhat equal, the outlook for the patient under treatment for states of anxiety that are induced from sources outside the patient is superior to the prognosis in instances in which the anxiety springs more or less unaccountably from the unconscious of the patient's mind. This observation deserves repetition because of its bearing upon the therapeutic outcome. The physician is cautioned, however, to make certain that he is well-fortified *with facts of the patient's life* before he draws any judgment as to the relative weight of inner and outer causes. Without such facts, it is easy to misjudge. The physician's loyalty to his patient may cause him unwittingly to decide in his or her favor, even when as not infrequently happens, the patient insists on taking full responsibility. It cannot be forgotten that *a child, repeatedly injured emotionally by a parent, may be so conditioned to the injury that the feeling of injury may fully control a more deeply lying resentment against the person who inflicted it.* These

people do not have the mental strength with which to oppose the one who harmed them so severely, perhaps for one or more of several reasons. One has been mentioned: the continual bombardment of the child's mind with the sense of guilt or sin or injury. Usually a child so browbeaten cannot go to the other parent for solace, because the aggressive parent often stands between the two, openly or tacitly forbidding them to get together.

Such a family situation prevents any natural display of affection and causes deep hostility in the child, who is too small to offer overt resistance. Yet, the child's animosity grows with the years. Even after the demoniacal parent is dead, the child's hatred may not, usually does not, find release, save through anxiety, the origin of which is not known to the patient. These people do not "enjoy suffering." They are plagued by it and ordinarily cannot get rid of it except by psychotherapy.

A second general source of anxiety is the individual's unconscious life. From the very early years of life certain groups of individuals show an inability to detach themselves from their parents in ways that are normal for their age. *As a rule the son is unduly bound to the mother and the daughter to the father.* In either case the parent of the opposite sex also acquires a position of eminence in the child's mind, but it is usually a concealed position. In the case of the son (but it is essentially the same for the daughter with respect to the father), it appears that, apart from mother's attitude towards him, he cannot get away from the desire to possess and be possessed by her. If she is endeared to him, it is never quite enough, for he is always seeking more. Often it can be demonstrated that he had the same impulse to be inseparable from her while he was at the breast. Weaning is commonly difficult for such a boy. Indeed, in his later years, perhaps, through maturity, his general reaction to people is a suckling one. He does not get weaned physically or emotionally. These people remind us of Swinburne's line in *Laus Veneris*.¹

"O breast whereat some suckling sorrow clings."

¹ Reprinted from *The Works of Algernon Charles Swinburne*, Philadelphia: David McKay Company.

These children are beggars of love and never seem to be satiated. Like grown-up beggars, when their plea for (emotional) alms is insufficiently rewarded, they whine and get into tantrums when their desires are not fulfilled. A youngster already inordinately satiated with affection stamps on the floor and goes into a near-convulsion when mother diverts her attention from him to another. Her best efforts to wean him from her are at most only faintly successful. He soon learns how to wheedle her into affectionate display.

He is a model child at home and in school, though it is also clear that he is as willful as he is obedient. Notwithstanding his soft voice, there can easily be detected in him a domineering attitude that commands submission. Through it all, there is the quality of dependence which he seeks and usually acquires by persistent cajolery.

He is kind to mother so long as his demands are met. He returns quickly from school, seeks to run errands for mother, or to do chores around the house. He recounts school events that buttress her esteem of him. He works his intelligence to full capacity in matters of scholarship, gaining additional recognition from his teachers. As he grows older his affection-begging is not much different with men than it is with women. *All people are potential mothers to him.*

Psychiatrists know all too well the deep meaning of the concept that *people are to the neurotic individual what he conceives them to be*. What they really are may have no more than an intellectual bearing to the patient. His emotional mind, so to say, depicts people as it would have them appear. This general idea is also seen in normal people. When we are eagerly waiting for someone, the most dissimilar footsteps sound like the ones we are expecting to hear. Critical judgment is suspended in favor of the wish. This form of wishful thinking can become so prevailing, particularly when it stems from the unconscious, that it can condition a person in all his or her environmental relations.

For example, a very discerning young man, discerning intellectually, met all people as if they were men. He acted towards women

exactly as he acted towards men. He was a "rugged individualist," always fighting his way through life, always feeling that people were "putting him on the spot." In his own words, he made no distinction between men and women. They only dressed differently. Even on the rare occasions of physical intimacy with women, he could not quell the belief that anatomically they were males.

Another patient "saw" what he wanted to "see." On surveying his experiences with women, he was startled to realize that all women to him were motherly. There was an inner force in him that required all women to be maternal to him. The immediate reason for his seeking psychotherapy was the appearance of severe neurotic symptoms contingent upon a marriage to a woman who was much too much the mother.

Returning to the child who cannot give to or receive from mother enough love, it appears that the undue attraction, *per se*, has no special diagnostic significance, for it can be seen as the background of many separate types of individuals. When observed in the introverted child, it may be the foundation for subsequent schizophrenia; in the extravert, it may be the forerunner of a manic-depressive psychosis. Then there is the youngster who, possessing this psychology, does not seem to lean heavily in one or the other of those two directions. Beneath his suckling attitude is an emotional set-up that partakes of both. Perhaps the difficulty eventuates in his inability to grow up emotionally. He gets fixated at the early mother-son level of adaptation.

He falls barely short of the requirements for adequate social adjustment. Often he is a leader among scholastic and athletic groups; he is usually honest, straightforward, sincere, even if a little too impersonal and literal in the handling of his assignments. People like him for his constant application to work and his intellectual impartiality, though they realize at the same time that he lacks personal warmth. His friendly, warm disposition is intellectually, not emotionally, conditioned.

Already, in early childhood, his general personality tendencies show that he is a man-boy, that he is too mature for his age, as one would say. He does not *romp* around with other kids of the

neighborhood for the sake of sheer fun. He makes tasks out of hobbies. Throughout his activities, one senses the bid for commendation and the unconcealed pride in accomplishments, as well as more than ordinary sensitivity to criticism. Quick and capable in matters of intellectual defense, he is stalled when a situation calls for the solution of a problem by emotional means; under such conditions, he uses the only grade of emotions available to him, those of a puerile or infantile character.

His emotional immaturity is particularly telling in his relations with girls. His standard of propriety is too rigid and trying for the girl who likes him, because he meets her emotions with his intellect. Discussions on intimate topics are developed along philosophical lines, often with quotations from authorities. Nascent love-in-the-making takes an educational course. This is no less disturbing to him than it is to her, because he, too, is restless under the pressure of the love-impulses of nature. The unconscious loyalty he owes to his mother checks the outward expression of his instincts at the level of the inner conscience.

During the years of adolescence and early maturity his inner conscience (*super-ego*, parental code) is constantly beset by his instincts, but it is adamant and will not let them cross the boundaries of its domain. In taking such a stand, however, the rigid image of the parents, in this case of the mother in particular, is infiltrated with the instincts. This means that, among other things, the image of the mother is in control of his sexual urges.

To those who have been snatched from the ravages of a mental disorder, it must seem strange to hear the idea expressed that "the image of the mother is in control of a son's sexual urges." Yet, such a state of affairs is not uncommonly encountered among psychiatric patients. It can be better grasped when it is realized that the patient's conscious life is at the mercy of his inner instinctive self, an inner self that makes categorical demands and does all in its power to see that the demands are fully met. For us, for the efforts we make to live peacefully with ourselves and with others, our instincts have no more respect, no more consideration than they have for the laws of man which strive to regulate our morals. Instincts

are ruthless. To gain their goals they have no compunction in sacrificing the individual upon their own altar. That is exactly what they do with people who fall ill of a mental disorder.

In extreme instances, as in schizophrenia, the instincts operate right out in the open. The schizophrenic patient is totally defenseless against the instinct that compels him to feel, think, and act the role of God, or to act overtly as a bisexual being, or to believe that he is the universe, or to take the marital place of his father with respect to his mother. The instincts force him into sexuality with his mother.

The role of the instincts is not hypothesis. It is real, clear-cut, demonstrable. The situations just related are in daily evidence among schizophrenic patients, as available to anyone's observation as they are to the psychiatrist's.

The schizophrenic patient often succumbs completely and overtly to the instincts. The situation with the psychoneurotic patient is different. He, too, often succumbs completely, but, disguisedly, not openly. He still has the capacity to cover up the real motives of the instincts. He can compromise by concealing the bare facts with a blanket of symptoms. He is thus assured that neither he nor his associates will ever know the underlying truth so long as the blanket of symptoms covers it.

However, when through psychotherapy the blanket is slowly pulled to one side, exposing what is beneath it, the patient is usually aghast to gain a glimpse of what is going on "behind his back." He comes face to face with disgusting and immoral scenes. They are there; the psychiatrist does not make them. He only assists in their exposure. The patient sees a part of himself, a part which he detests and from which he recoils in horror; he sees his instincts in unhampered activities with the ones dearest to him, his parents. Certainly he is plagued to distraction.

It is not his fault that he has instincts; nor is he responsible for the awful things which they do; nor is it the fault of his parents. Why call it a fault at all, unless by that term we mean a troublesome attribute of nature. Let us call it a fact, just as we know that often the organs of our body are damaged by vestigial growths,

which are recognized as throw-backs to the earlier evolution of the organs. The instincts are within us; they are powerful, at times implacable, often in greater control of our lives than our conscious selves are. Sound mental health is a reflection of the individual's ability to keep the instincts in check until the appropriate time and occasion make their release desirable from the standpoint of the person and the society in which he lives.

The patient's unconscious makes incest with his mother an issue of great concern to him. To be sure, he does not know that there is anything even remotely resembling incest in him; all he knows is that he is plagued with unaccountable anxiety, which is steadily wearing him down, reducing his intellectual efficiency to a dangerously low level. It is not a figure of speech to say that the instincts are on the march against the forces of scholarship and honorable living; it is just what is happening. When the psychotherapist looks behind the bulwark of scholarship, he sees the crude and relentless instincts, which in their growth have advanced no further than the patient's mother and father and in their struggle for existence are devouring the only things at hand. The instincts do not elect to stop at the parents. They are not satisfied with that kind of subsistence. They struggle violently to escape from the parents, accepting them only as a last, inevitable means of survival.

If this sounds melodramatic and far-fetched, as it may very well to those who have not seen beyond the plainly visible evidences of living, it should be known that it is not a fiction of the physician who is helping the patient to investigate the cause of his troubles, but it is the ungarnished truth of the patient's inner mind. It is certain that nobody would wish it for himself, least of all those whose lives are ravaged by it. The pleasure that the psychiatrist derives from its exposure is equivalent to that felt by the physician who finally reaches the cause of a debilitating disease, thus bringing it within range of cure. It is not an inviting situation, but is there anything wholesome that incapacitates us?

Neither the patient, as he is consciously constituted, nor his inner conscience wants to become party to such a disposition of the instincts. Yet, no matter how hard he labors, he cannot divert them

to external objects. He may strive to do so by a precipitate marriage, but he has been too long and too intensely conditioned emotionally to his mother to apply his instincts successfully to a substitute. The instincts, however, must leave the attachment for the parents, in part at least. The tension in the unconscious part of the mind must be lowered.

In the normal individual instinctual energy is drained off through three main channels, (a) the body, (b) the mind, and (c) the intellect.

During the early years of infancy, the energy courses largely through the body, having two and later a third zone of major importance. These three areas (known as erogenous zones), because of their heavy infiltration with energy, acquire unique distinction in the life of the child.

THREE PRIMARY INSTINCTUAL ZONES

The term *erogenous zone* was appropriately given to these three zones during the early formulation of psychoanalytic doctrines, because attention was then almost exclusively devoted to the erotic or constructive instinctual component, while little was known about the thanatotic or destructive instinctual element. Over the years that followed, information on the latter grew steadily, until the thanatotic component gained distinction equal to that of the erotic. Hence, today one speaks of instinctual energy, implying both the erotic and the thanatotic.

1. From the date of the infant's birth, a large share of instinctual energy is invested in the *oral zone*, drawn there by the need for nourishment. The breast-fed infant thus establishes close physical union with the mother. In the very beginning the infant is conditioned to the breast and it is believed that this conditioning reinforces the instinctual oral habits with which the child is born.

If nourishment from the breast is *gratifying*, then this mouth-breast combination acquires high importance to the infant, because naturally, without "knowing" it, a pattern is established by which a little whining is promptly followed by fulfillment of the infant's need for nourishment. It is believed that the *time* element is signifi-

cant in and of itself. The infant whose oral gratification is *immediately* forthcoming is said to be habituated to prompt and satisfying action. Until this habituation is taken over as a mental attribute also, it exists in the form of what might be called "body memory."

From the start this infant is accustomed to *immediate fulfillment*, which, if it continues into the phase of *mental* development, gives the infant the mental feeling that its needs will be promptly and fully met. Thus there is a *bridging between body and mental memories*, leading to the assumption that *body traits are instrumental in the formation of mental traits*. If this opinion is true, then the happy, satisfied child of later years is, at least in part, the outgrowth of a happy, satisfied, infantile body upbringing.

The infant's oral needs may not be met promptly. There may be long delays, which, if habitual, may be accompanied by petulance, by the feeling that gratification may never come, by helplessness and insecurity. At first these are *body* expressions, body memories, so to say, and they may be taken over by the developing mind, appearing later as character traits. This is particularly true when mother continues to withhold gratification of the infant's requirements, not alone with respect to oral needs, but also to other needs of the infant. So conditioned, an infant may grow up with character traits of impatience, insecurity, hopelessness, helplessness, pessimism. This aggregation of character traits may stamp the child in later life as having a *character neurosis* or it may, to a greater or lesser extent, contribute to a full-blown neurosis or psychosis.

Then, again, it seems significant to know whether, after the long delay, the infant's oral needs are fully satisfied, partially satisfied, or, perhaps, only meagerly so. Whatever the condition may be, it appears to leave its impression upon the infant.

There are instances, also, in which mother meets the infant's needs promptly, but she is resentful and shows it by spanking the infant. When gratification comes only with resentment or hurting, a pattern may be formed that may be carried over into the later years of the infant's life. Evidently the situation is made

worse, when resentfulness is followed by incomplete gratification.

It is thus seen that, from the standpoint of the erotic or constructive instinctual component, in its oral manifestations, there are at least three major constituent elements to be considered, three each from the infant and the mother. They are the nature and strength of the erotic element and the physical health of the infant and the mother.

The destructive or thanatotic instinctual component also permeates the oral zone from the date of birth. It has little to perform there, when oral gratification is complete. Therefore, it shifts its interests to other parts of the body, appearing, under normal conditions as healthy, physical activities, such as bouncing around the crib and later in more grown-up types of play. A portion of the aggressive energy goes into biting and chewing.

At times, however, an undue amount of aggressive energy may lodge in the oral zone. This may be observed when the unsatisfied infant bites whatever touches its mouth, including mother's breasts.

This question of dissatisfaction is a relative one, as is the question of satisfaction. An infant's physiological needs may be fully met, yet there can remain in the oral region an additional quantity of either or both instinctual energies. Assuming, for the moment, that the aggressive energy is incompletely disposed of in the feeding process, we can understand that the amount remaining may be used up in such acts as biting or sucking. When this latter condition is more or less continuous during the period of feeding by breast or bottle, it is not unlikely that the unused energy, which in the early months is consumed in biting, may later express itself through words and speech. The infant may grow up to be sarcastic, biting, sharp, spiteful. Thus, we see again the displacement of instinctual energy from body to mental forms of activity.

The importance of the oral life of the infant rests upon two major considerations, first, *the instinctual energy invested in that area in the interest of biology*; second, *the management of the instinctual energy in the service of social adaptation*. Since it is the duty of the mother in particular to train the infant's instinctual energies to give up a fair share of their attachment to biological

goals in favor of social ones, it can readily be seen how great an assignment is given to every mother. The life of every individual is a *continuum*, beginning with the embryo in the uterus, then proceeding as infancy, childhood, adolescence, maturity, and senescence. There are no sharp breaks between any two successive periods of growth. On the contrary, each one passes almost imperceptibly on and into the next stage. During the transition from one phase to another, *the same energy is used, but it is applied to the newly developing habits of the phase that follows*. Living, therefore, consists in a steady substitution of the objects of instinctual energy, until in the well-adjusted adult much of the energy is consumed in forms of social or environmental activities which ordinarily do not reveal the instinctual source whence they arose. In this process of replacement of instinctual energy, a certain amount of energy always remains in its original site. Otherwise, there would be no activation of (for example) the body zones to which our attention is being directed.

This means that the two instinctual qualities, which for quite a while are lodged in the oral zone, are expected to give up some part of their attachment to the oral zone for distribution elsewhere. This sharing of the energies begins very early in infancy and spreads to many parts of the body. The *anal region* gains a position of importance in point of instinctual energy, often rivaling the oral zone in that respect.

2. The *anal area*, but in particular the contents of the anus, or, more correctly, of the rectum, is also the subject of both *biological* and *social* activity. Or, should we say, that the energies of that region are responsive to both *biological* and *parental* control?

From the earliest stage after birth, the care of the infant's anal area devolves upon the mother. Under normal conditions, she is as much interested in what comes out of the bowels as she is in what goes into the mouth. It is her duty to be concerned with the *frequency* of bowel movements and the *nature* and *quantity* of the stools. During the first several months of the infant's life, mother's interests and activities in that respect help to set up another zone of habits. Thus, there are two body areas being trained

simultaneously and in many respects alike. Regularity, cleanliness, quantity and quality of the materials passing through the zones are points in common.

From the standpoint of the psychiatrist another factor of great consequence is the *personal* one, namely, that *mother directs these activities, that she becomes a part of them*. She acts as if the infant's body is her body. Indeed, as soon as the infant can comprehend, mother often asks the infant to perform its functions. She becomes the infant's early mind, his *super-ego*.

We can apply many of the principles involved in the infant's oral training to its anal training. And we can postulate the same general transition of instinctual energy *from body to character habits*. Regularity in eating and defecating leads to regularity in the performance of, shall we say, environmental activities.

The general attitude of the mother helps to play a determining role in the setting of oral and anal habits. She has to contend with two major forces, first, with the control that *biology* has over the infant's instinctual energies, second, with the control that *she* has over her own instinctual energies with respect to her oral and anal regions.

When mother is pleased with her infant's bowel regularity, the infant senses and adopts the pleasure. When she is alarmed, the infant is alarmed. When she is resentful, the infant is. When she is disgusted, the infant is. When the mother has a pattern of reaction towards the infant's anal region, it is highly likely that the pattern will be the infant's also, acquired by *identification*. It is a pattern that may well spread to the infant's character traits.

When the pattern is applied to the infant's character traits, assuming for the moment that it is a sensible pattern, then the infant grows up to be neat and clean, regular, reliable, easy to get along with, proud of other's esteem of him, proud of himself. There are about as many variations of the pattern with respect to the anus as there are to the mouth.

The evolution of instinctual energies in their oral and anal manifestations often has a decisive influence upon the later life of the individual. What has been said about the energies of these two

zones has greater practical than academic value. No one is more keenly aware of the relationship of the oral and anal areas to the distress and anxiety of the psychoneurotic patient than is the patient himself or his physician. The faults of the *biological*, as well as of the personal management of the instinctual energies connected with these body zones are frequently the cause of the most frightening ways of living—the psychoneuroses. In the fully developed psychoses, ordinarily, though not always, the instinctual energies of the individual gain and maintain control, usually expressing themselves as they had in the patient's early infancy. They then stand in intimate relation with the mother, though they can and often are shifted over to the father.

We can best understand the displacement upon the father, after we know what can happen to the instinctual energies when they pass from the oral and anal zones to the sexual area.

3. The *sexual part* of the body gets energized very early in infancy. Usually, however, it does not become prominent until about the second half of infancy. By this time the average infant is already distributing his energies in several directions, including play, exercises, games, learning about his surroundings, etc. Hence, ordinarily there is not the same concentration of energy in the sexual zone as there had been in the oral and anal regions. As a consequence, what energy there is in the form of sex would be easier to handle if it were not for the fact that sex is a primary, biological urge and, perhaps what is equally important, that its functioning must be deferred for many years beyond infancy. From the personal point of view, it must be *deferred and silenced* for about the succeeding fifteen years, more or less. There is no other function of the body subjected to such severe disciplining. Even when the urge for *knowledge* of sex is small, too frequently it is treated by parents as the sin of sins. It must be a gigantic dilemma for a child to realize that its parents, who advise and direct so liberally and openly on all other topics, put a complete ban on questions of sex.

What happens to the instinctual energies when they reach the sexual stage in the early years? Some part of them usually gains a meager outlet through masturbation. Another part may find partial

solution through peeping at the parents or others. Still a third part may be lived out with other children through sexual acts or discussions. A fourth part, but an exceedingly important one, goes *back whence it came*, either to the oral or anal zone, or to both. In its return to either or both of these areas, *it carries the sexual imprint with it*. This means that the oral and anal regions take on a sexual coloring. The coloring will be as intense as the strength of the sexual energy which it takes to the oral and anal regions.

But, that does not tell the whole story. In the unconscious, that is, from the distant heritage of the past of mankind, sexual urges are united with the mouth and anus. One or two references may make this point clear. In the deepest layer of the mind is the concept of *oral impregnation*. It is "believed" that babies are the result of eating. It is likewise a primitive idea, known as an *unconscious phantasy* in the unconscious, that babies are born through the anus. There are many other primitive concepts relating sex with the oral and anal regions, and these concepts often come into the conscious part of the child's mind, when the truth of sexuality is not at all known by the child.

Now that the sexually tinged instinctual energies have been driven back from the *genitals* (the reproductive organs) and have found lodgment in the oral and anal regions, they can be directed to the parents, to one or both, because the original intention of the energies is concealed. The energies, partly sexualized, appear as oral expressions of love, or, when the child tries to repel the sexual connotation, of hate. Parents and children often act as sweethearts to one another, provided the sexual significance is disguised.

The instinctual energies, earmarked for sex, are drawn to the genital region almost in full measure at puberty, when the sexual apparatus and all its collateral glands become mature. Then there is the long drawn-out process that finally culminates, when it does, in marriage and direct release of sexual energy through the genitals.

(a) Instinctual energy stemming from the source of the instincts, namely, the *Id*, first attaches itself to these three and to other body regions. Since the child's energies are supervised by the parents, the energy connected with the body areas thus has a large

quantity of parental coloring. When mother is more or less responsible for directing the child's activities, it is clear that the energies of the child's oral zone are mother-conditioned. The same general condition prevails also as regards the anal and the genital zones, with considerable hush-hush about the latter.

The point of special interest to us at this moment is the fact that the tensions of the instincts, at first more or less exclusively at the source of their origin, fan out over the body. In so doing they establish pathways from the *Id* to the body areas. By constant usage these pathways get well-worn into ruts and become patterns of habit. One of the end-results of the distribution of instinctual energy from the *Id* to body zones is the lowering of tension in the *Id* area.

In each of these steps, a certain amount of energy always remains in the place whence it originates and in those areas to which it later becomes attached.

(b) With the very earliest beginnings of mental functioning, instinctual energy goes over into the service of images and ideas created in the mind. It is believed that the developing mind does not have special energy assigned to it, but that the energy it receives is drawn from the body areas to which reference was just made. This redistribution of energy serves a double purpose; first, it reduces the energy, that is, the tension, in the body zones; second, it vitalizes the contents of the growing mind.

As with the energy in the child's body, so with that of its mind, it is supervised for a long time by the parents. Thus, the energy of the child's mind possesses a strong parental coloring. The combination of the body and the mind of the child, or, rather, the mental images which the child develops of its body and mind, together with the incorporation of parental disciplines, constitute the *super-ego*, sometimes also known as the *inner conscience* or *second nature*. First nature comprises the undiluted and unmodified instincts.

(c) When the child is old enough to join interests with others, his or her energies begin the long process of externalization upon an ever-widening horizon of environmental objects. This progres-

sive spreading out of energy serves to prevent the piling up of it in any one place. The emotionally healthy child puts his excess energy in a variety of locations and circumstances both within and without the parental home. This means that there is a steady refining of instinctual energy, to which the name *sublimation* is given. The energy itself does not change, but the objects to which it becomes attached keep changing. A few examples may make this clear. The early interests that the child has in his body are later partly given over to the clothes he wears. His interests in mud-pies and uncleanness are diverted to the making of clean things and cleanliness. The selfishness of the child gives way to consideration for others.

(d) Some of the energy originally stored up in the body remains there, but takes on new forms of expression through athletics, constituting more or less direct sublimation, and hence a reduction of tension in earlier and now less suitable types of activity.

(e) The *intellect* of the individual is one of the most prominent reservoirs of mental energy. In many people it is of supreme importance as a medium of sublimation. Education of intellectual attributes is to be highly desired, if for no reason other than its great value in drawing energy to it, energy which otherwise might have to find an outlet through body channels. One need not have any special concern about the quantity of energy which the body keeps for itself. Ordinarily it has sufficient for its needs, although it is always reaching out for more. There is no glutton like the body. The well-adjusted individual is one in whom energy is not excessively stored in any one place.

(f) When for one reason or another a person's energy cannot be adequately distributed along the channels indicated in the foregoing, when it is blocked or the outlet-channels are insufficiently large or clogged, it remains within the person and is felt as tension. It remains active until it finds some way out. It is not clearly known why it cannot get out. The theory of *fixation of energy* seems to describe only what happens, without telling why. One reason why energy remains close to its original objects of outlets, namely, the individual himself and his parents, may rest in the

fact that he (or she) gets excessively conditioned to infantile or puerile ways of living. Whatever the reasons, it is a known fact that energy can and does get bound up in infantilism.

When mental infantilism is so severe as to prevent the individual from indulging in activities normal for his age, great tension commonly results. The tension mounts until it finally breaks through. Sometimes, as in advanced schizophrenia, the dam is burst so wide-open that the debris of infancy is carried along with the flood water. At other times, as in the psychoneuroses, the breach is relatively small, yet permits a large, powerful and steady stream of energy to escape. When it is released in this comparatively safe way, little or perhaps no damage is done. But even so, there is always the danger that the pressure from behind the dam may steadily widen the breach.

When the latter occurs, especially when the breach is at the foundation of the dam and is thus not easily detectable, one may see only the seething waters without knowing the cause. Psychoneurotic symptoms may be likened to the local seething in an otherwise normal-appearing stream (of life).

The foregoing general orientation with respect to the origin and course of mental energy should help us understand more clearly many of the errors of emotional growth that enter into the formation of a psychiatric disorder.

When a parent is in doubt as to the emotional growth of a child, it is preferable to seek advice of a psychiatrist or a psychiatrically-minded physician. *It is commonly inadvisable for the parent to act as a psychiatrist*, which not a few try to do, because his or her own emotions, being an intimate part of the child's life, act as a barrier to objectivity. Either parent is too likely to see only what he or she wants to see. The parent should be suspicious of his judgment if his observations of the child arouse unduly deep and lasting feelings in him. The parent is certainly entitled to concern, but it should lead the parent to seek the assistance of a qualified expert.

It should be remembered that *it is entirely normal for a child to be bound to its parents and for the parents to be bound to the child*. The tie-in is normally very secure in early infancy, less so

in later infancy and progressively less during the succeeding years.

Perhaps one of the best guides for parents, as well as for the psychiatrist, is *the carrying over of one period of growth into the next or succeeding period*. It is potentially dangerous when a son or daughter carries infantile habits and emotions (up to the fifth year) into and through the period of childhood (extending from about the fifth to the twelfth year). It is dangerous, too, to go through adolescence with the equipment of childhood, and through maturity as an adolescent. For the parents and child (if he or she is old enough) who want to see on what basis the child (or the parent) is getting along, there are general observations that the average individual can make and value.

Parents have the advantage of being the first to examine into the possibility that the emotional bond is too loose or too tight, or too long extended, and to estimate roughly on which side the fault, if any, lies. *An important point for all concerned is to take any action slowly*. More harm is done by precipitate moves than by ill-considered ones. Do not forget that nature prescribes a very slow and gentle transition from one stage to another, allowing plenty of time for the abandonment of an old trait and the acquisition of a new one in its place. *Do not try to do in a week what normally takes a few years to accomplish*. This is not undue conservatism; it is simply following the best-known pattern, one that has had the advantage of centuries of application.

Remember that nature takes five years to develop an infant, about seven years to change the infant into a child, and some seven or eight years to convert the child into an adolescent. It is less certain how long it takes to change from adolescence to adulthood or full maturity.

It is not difficult to appraise the more pronounced manifestations of abnormal concern in the child, particularly as it approaches the realm of morbid anxiety. Often the first and most pressing source of the trouble is to be found in the parents. Many a child is saved from a crippled emotional life through changes in the attitude of the parents or of one of them, as the case may be, without any direct action being taken towards the child. This, of course, is not

of the aggressive, *thanatotic* type, again one each from the child, the mother and the father. This combination in itself would make any individual's emotional life complicated, yet, we must further add that *each separate instinct has its own special attributes*. Mother's love and hate components were fashioned for adult use by experiences characteristic of her earlier training and life; the same happened to father's love and hate instincts; then the four act upon the child's two instinctual drives to produce something different. The growth of the emotions is no less to be marveled at than is that of any organ of the body.

For purposes of exemplifying the course of the instincts as it is commonly observed in anxiety hysteria, we traced the tender instinct from its origin in the unconscious to its union with mother's tender instinct. We saw that the union of child's and mother's love instincts was what made the child unable to separate them when the situation necessitated disunion in the interest of sound mental health. Then we observed that when the union became unbearable because of the strength of the sexual component, the child's instinct was wrenched from the mother as pictured in the child's mind and again presented to the conscious mind as *anxiety*.

However, the development of anxiety is rarely quite so direct, because the love instinct is not so isolated in real life, and even it is more or less influenced by the aggressive or thanatotic element. In actual practice, therefore, the two instincts, or, more properly, the three pairs referred to a little while ago, are studied and treated in all their combinations. This is surely a complicated matter.

In the interest of completing this picture of the emotions, we shall mention another complication, the details of which are not going to be given here, because they belong strictly with experienced psychiatrists trained in psychoanalysis. It embraces the course of the instincts through the three major body zones—the mouth, anus, and genitals—and includes not alone the instincts of the child with respect to those areas, but also the part that, by word or action, the instincts of the parents play upon those areas of the child's body.

There are patients—and the treatment of them is long and ar-

duous and too frequently inadequate—whose mental energies have substantially never grown away from their infantile attachments to these zones. When the patient's energies are fixed on the anal and the oral zone, psychotherapy is often unsuccessful. One reason is perhaps that memories of that early period of life are not recoverable and, as yet, there is no wholly satisfactory technique for treating the emotions which cannot be conveyed by word of mouth. We say that the events of those very early years, momentous as they are in the later life of the individual, are recorded in the unconscious as *organic memories* and as such they can be understood at present only by the physician's own interpretations, not through eliciting information from the patient.

Repeated reference to *organic memory* has been made in this book, as if it were a well-established fact. Perhaps it is. We know that the human being carries in him a whole set of primitive impulses, amply re-enforced with ideas, which are said to be reproductions of the ancestral mind of man. They include such percepts as the castration phantasy, rebirth, cosmic identification, bisexuality, omnipotence, etc., percepts that are not known to enter the child's mind through any personal experiences. They come from the child's mind and our most reasonable explanation is that they are patterns of the *racial mind* which nature had laid down eons ago.

If they are *organic memories*, they at least have the quality of being recovered from the mind of the individual in much the same state as so-called *mental memories*. There is no distinction to be made between the *manner* of conveying archaic mental attributes and those personally experienced by the individual. For example, in describing an experience he had at the age of seven, the schizophrenic patient uses the same mental machinery (i.e., words and ideas) as he uses when he describes himself as God and gives details of his duties as God.

The term *organic memory* does not adequately convey what we intend it to convey. It is an expediency that may be employed until such time as we come to a clearer understanding of the state or condition in which primitive concepts exist within us. Possibly

there is no essential difference in the condition in which primitive and personal experiences are held. It is not improbable that another factor may play an essential role, namely, that a barrier of some kind is set up which separates the archaic part of the mind from the modern part. It is a weak barrier, to be sure, because it does not hold back the primitive mind in the infantile period of life and it certainly breaks down completely in advanced instances of schizophrenia, because the schizophrenic patient gives full vent to his or her primitive past. If we could know what the barrier is, how it is constructed, we might then be well on the way to a new and different cure for mental disorders. It is even probable that *psychotherapy, as we conceive it today, might not be at all necessary.*

It seems to be a reasonable assumption that one of the main differences between a normal and an abnormal mind is the inability of the latter to hold the primitive mind in abeyance or to keep it under control. Freud suggested that this failure might be due to the *fixation* of instinctive components in the primitive mind. Why are the instincts so fixed? Can the experiences of infancy sufficiently explain the differences between the normal and the abnormal mind? There has to be some other answer and it is not altogether unlikely that the answer may turn out to be related to *the condition in which organic memories exist.* Because we are totally in the dark on this issue, we have to set up some plan of approach, some working hypothesis. At the moment it is genuinely a guess to suggest that the activities of the mind depend to an unknown degree upon the organic substance or substances through which they operate, or by which they are conveyed.

So-called *organic memories* are in all of us. Everyone harbors within himself or herself the elements of primitive mentality. Under what conditions do they break out to take control of us, and, in so doing, prevent or hamper a normal course of living? Maybe the answer is to be found in connection with the commonplace observation that experiences of our infancy, so rich, varied and powerful, are not recallable to any appreciable extent. What causes them to be unavailable to memory? These and kindred questions

wait upon future research. In the meantime we must do the best with what we have.

Anxiety, as we see, may have special connection with the parents by way of one or more of those three so-called *erogenous zones*. *When of these three zones anxiety stems only from early oral and anal instinctual involvement, none but very experienced psychiatrists should apply treatment measures.* On the other hand, although by no means easy, the refinements of technique are, as a rule, not quite so difficult when the instincts are essentially fixed at the genital level.

Anxiety of the freely floating or unattached kind, that is, anxiety that appears to have no vehicle of expression except a few words, is called *anxiety hysteria* when it occurs in one with a hysteroid type of personality. But in that same type of personality the instincts, pent-up in the unconscious, may flow into one or more organs of the body, inducing a psychosomatic state known diagnostically as *conversion hysteria*, the effects of which upon the individual are much the same as they are when the anxiety is unattached. The underlying causative factors are the same in kind in both instances.

The inclination to resort to some physical complaint or to capitalize upon a real illness in order to get what they want is the usual earmark of children who may later develop *conversion hysteria*. Putting it this way may make it appear that conversion hysteria is a stratagem of conscious design, but it is not so in its full-blown state. Ordinarily it has its origin in real or alleged illnesses in the early years of growth, but there are other prerequisites for its development. Perhaps of primary consequence is the inordinate yearning for attention and affection, not unlike that seen in the individual who later develops *anxiety hysteria*. The child may soon find out that physical sickness is an effective means for gaining love and kindly attention, whereupon he resorts to that condition when the need arises. He (or she) gets so conditioned to it that it acquires a likeness to second nature, receding with time into the unconscious in the form of a reflex beneath the threshold of consciousness.

Conversion hysteria in mild and transitory form is a widespread phenomenon, as a rule innocuous, but always carrying the possibility of assuming morbid proportions. That is particularly true among children who cannot emancipate themselves from their parents and who, usually in the later years, are unwittingly beset with the inability to extricate their instincts from the unconscious image of the parents. As in anxiety hysteria there is finally a violent wrenching away, the instincts going into and affecting one or more organs of the body. An organ that harbors an "imaginary" illness harbors two things: (1) tension created by the energy of the instincts; that is what the patient feels; (2) the idea or complex connected with the instinctual energy.

Thus, a young man, overly fond of his mother, and she of him, began to try to emancipate himself from her. Recognizing his first efforts at separation from her, mother forced herself upon him. She acted more than ever as his sweetheart, showered him with kisses and embraces under the pretense of being anxious, because he seemed sick and unhappy. She even suggested that perhaps sex was the cause of his uneasiness and under further questioning by her, both were convinced that it was so. She questioned him closely on sexual matters, while she showed her deep concern by embracing him. Sex and mother were the theme.

Soon the boy began to complain of a sick stomach, at the same time that he was trying to drive thoughts of sex and mother from his mind. The topic that plagued him—sex and mother—gradually disappeared from consciousness. But now he was plagued by his stomach, plagued to about the same extent that he had been when the topic was sex and mother. His first trouble had not left him; it simply went out of his conscious mind, into the unconscious, and reappeared in the disguise of stomach trouble.

That sounds strange. What is it that disappears and then reappears in another form? Extensive experiences in the study of such processes demonstrate that *the complex itself, in this instance, incest, and the energy of the complex take the form of an organic illness.*

This kind of instinctual behavior has already been described in

former pages and therefore need not be further elaborated here. What we need stress at this point is the psychological similarity between anxiety hysteria and conversion hysteria and to call attention to the fact that the purposes of both are very much the same.

In full-fledged form, conversion hysteria may be represented by complaints that may be related to one or more organs or organic systems of the body. The motor (muscular) system may be involved, with partial or complete paralysis of one or more limbs. The paralysis may result in inability to stand (*astasia*), or to walk (*abasia*), or there may be tremors. Sensory symptoms may appear, such as absence or exaggeration or perversion of the sense of touch. The organs of special sense may be included, giving rise to blindness, deafness, loss of the sense of smell and taste, or these organs may become morbidly sensitive to their respective stimuli. Visceral, that is, abdominal and chest, organs are frequently disordered in conversion hysteria, giving rise to difficulty in breathing, choking sensation, heart symptoms, nausea, vomiting, loss of appetite, constipation, etc. The symptoms may be related to the brain and its connections, producing headache, confusion, loss or alteration of concentration, loss of memory, dizziness, etc. The mind itself may suffer in ways other than those associated with anxiety; love, hate or depression may be so prominent as to throw the patient into a panic; or each may be "absent," the patient being without feeling. The patient may lose all knowledge of himself or herself, that is, be depersonalized or may have the distinct feeling of being two people.

Gradually the concept of hysteria is being extended to include some other groups of symptoms that have until now waited for better understanding. That is the case, for example, in the disorder called *traumatic neurosis*, the further study of which seems to lend support to the idea that the fundamental problem rests on a hysteroid basis—with the physical injury or trauma playing but a precipitating role. The physical factor may be mild or severe, but it is one thing, and the mental symptoms stirred into action by the physical disturbance constitute a thing apart. Usually the diag-

nosis, traumatic neurosis, places emphasis on the dominance of the mental features. It is coming to be an accepted opinion also that in this situation the physical injury usually upsets mental equilibrium in the conscious sphere and the name *ego neurosis* is intended to impart this notion. The symptoms revolve mainly around the mutual relations of the conscious ego and the environmental adjustment of the patient. For instance, a man, finding it increasingly difficult to hold his position in society, may develop physical and mental complaints of inadequacy following an injury which in itself does not appear sufficient to cause his symptoms. However, the symptoms give a certain amount of plausibility to his disabilities. When such a series of events causes one to give up his wage-earning responsibilities and to seek reimbursement by the state or by his employer, it is said that he has a *compensation neurosis*.

The same generally accepted view is gaining strength also with respect to certain patients who show what is called *occupational neurosis*, a condition in which invalidating symptoms appear, usually in connection with parts of the body that are mainly used in the type of work done by the individual. Some occupational neuroses seem to be definitely organic in cause, others mental. A person standing all day long at work may complain of weakness of the lower extremities, which upon the most careful examination may be found to have been strengthened by such use. Investigation reveals that he is unhappy with his job because it does not pay enough; besides, his wife has been showing increasing discontent with her allowance and lately has been referring to the well-paid positions of their friends. If he is unable to rise above his inferior salary, he may fall below it, so to speak, through physical complaints that serve to release him from the unwanted work without losing the respect of himself or of others. He is spared the "stigma" of inferiority from the point of view of his personality.

Another group of individuals, small in number, comes under the attention of psychiatrists, because these individuals, too, show disturbance in the conscious ego field. Their ailment takes the diagnostic name, *Ganser syndrome*, because the condition was first described by Ganser. Some individuals, facing criminal respon-

sibility, attempt to avoid trial and punishment by recourse to a peculiar set of symptoms comprising "the syndrome of approximate answers." Their answers to questions are relevant to the general topic, but are never correct in particulars. When shown a dollar bill they call it a five-dollar bill; they call a match a cigarette, connecting the two, but they use the match as one would use a cigarette; a comb is a brush or something to use with the hair; they say they have six fingers, that there are fourteen months in a year. By doctors and lawyers these individuals are usually regarded as "without a mental disorder."

Still another and very important group is made up of those diagnosed as having a *war neurosis*. It is recognized that the conditions of war and of warfare may, (1) cause a neurosis in an individual who is subjected to sufficient external violence, (2) precipitate a neurosis in one already susceptible to it. In both instances external situations play the dominant role. (3) In a third subdivision, however, there are individuals who cannot master their fear of injury or cannot bear removal from their usual places and ways of living. Though in it, they "escape" military service by way of one or more of the multiple symptoms observed in hysteria.

The course of hysteria varies considerably. Often it is periodic and of relatively short duration, though in others it may become chronic. The instances of hysteria stemming from legal, financial or war causes may last for a long time, many continuing far after the external condition has been removed.

Fear

Fear is common to all psychiatric disorders. With some individuals it gains and holds great prominence throughout the course of their illness, while in others it gradually recedes, until replaced by normality or by the dominance of other symptoms.

Fear is a symptom and not a disease. This point needs considerable emphasis, because almost all patients with morbid fears regard them as the causes of their troubles, when in truth they are results. We see this all too readily when the fear is normal and reasonable. A man fearing a mad dog recognizes that the fear is secondary to the dog. He realizes clearly that, in the fear of lightning, the cause is lightning, the result is fear. This cause and effect sequence holds as true with regard to morbid fear, but since it is a reaction to something within his mind, something about which he dare not let himself know, the patient believes fear to be the original cause of his troubles. He does not use the same type of thinking with respect to aches and pains, for in such instances he promptly tries to seek out the source of the symptoms. He ascribes soreness of the muscles to excessive physical activity in which he engaged the day before. He traces headache to constipation; buzzing in the ears to a cold; pain in the abdomen to gas. He knows that *symptoms are merely signals* which warn him that something is wrong, but he has not learned that the mind has its special ways of notifying him that *it is out of order*. Anxiety, fear, obsession, compulsion, delusion, hallucination, illusion, and the great array of physical complaints stemming from the mind are the counterparts of the well-known physical symptoms. They are also called *symbols*.

To the patient an obsession is an obsession and nothing else.

While he believes that it is a mental phenomenon, still he acts towards it as if it were something as circumscribed and discrete as a foreign object, such as a bullet. He knows that it is within him, but he does not connect it causally with anything else within him. The reason for his attitude is clear. *Obsessions are the consequence of emotional turmoil coming from impulses which are distasteful to him and, therefore, he wishes to conceal them from himself.*

Symptoms of the mind—obsessions, fears, etc.,—have been studied at great length by physicians. Laboratory men have spent their professional lifetime on the most minute studies of the brain, but to date *nothing of a positive nature has been revealed showing any connection between brain tissue and, say, fears.* The most exhaustive experiments on the brain have yielded nothing in this respect. The finest biochemical observations are equally without positive results. There are more than twenty specialties in organic medicine, each carrying on intensive research with outstanding results otherwise, but not one has thus far contributed anything towards an organic understanding of symptoms of the *mind*.

That the mind is connected with the body no one seems to question and it is not being questioned here. It does not seem reasonable, however, to assume that disordered functioning of an organ must always arise from the organ itself. A reservoir may supply healthy water to a home, but the water may become polluted through improper care by the consumer. The brain may route healthy energy along the nerves, but the energy may be put to disservice after it has reached its objective. The source remains intact, the ultimate results are foul.

Can we not apply the same reasoning to disturbances in the mind, particularly when the practical application of that type of reasoning cures the trouble? The body gives energy to the mind, but how that energy works is largely dependent upon what it has in the mind to work with and upon. It is believed that the body has two major kinds of energy, the one, (a) *anabolic*, engaged in the constructive activity of tissues, the building up of tissues; the other, (b) *catabolic*, concerned with the breaking down of tissues. The action of the two combined takes the name *metabolism*,

familiar to everyone. There is no reason to believe that the energy supplied to the mind is any different from that existing in the body. In the mind anabolic energy appears to be associated with constructive impulses, catabolic with destructive ones.

We do not know the seat of the mind. It is the general belief that it develops from the brain, yet all the world-wide, incredibly refined brain-research conducted thus far, has not yielded any clue to the seat of the vast collection of ideas and emotions that are possessed by the human being. Any adult can expose the innumerable details of his life experiences, taking up as much as hundreds of hours in so doing; still we do not know where it all comes from. Fortunately, however, this inability is not a drawback to treatment.

The fear to which primary consideration is given here is abnormal or morbid, the kind that originates in the sphere of the unconscious as a reflection or a virtual image of an unconscious set of turbulent ideas.

The ultimate origin of fear in any individual's life history is as yet undetermined. Normally it is already present at birth, as a general tendency with the purpose of protecting the infant in various impacts of the outside world upon it as a living sentient being; there is, for instance, the "fear" of loud sounds which, by reflex, causes muscular activity with a seemingly defensive quality about it; then, the "fear" of bright lights, of food that is too hot or cold, of objects that are painful to touch, of disagreeable odors—each of these "fears" seems to arise from the physical side of the infant and, as such, is perhaps related to so-called *organic memory*. The infant is alerted to potential or real danger by way of an instinctual response. The basis is already being laid for fearful reactions that are to be expressed in great profusion through the mind during the early years of growth. The infant is brought up on fear as a natural constituent of mental growth. It is inconceivable that an infant can be reared without fear or at least very deep concern being imposed upon it. Infants grasp the meaning of parental emotions long before knowing how to put the emotions into words. They soon recognize the parents' various movements as betokening love, hate, irritation, sadness, anxiety, and fear.

As soon as he leaves the crib and begins to creep around, the child is trailed by the parents, who stop him here and there, to admonish with a "no, no!", meaning there is danger in that object. If a needle or pin in the child's path on the floor is picked up by parents, the child takes over and shares the anxiety with the parents. The same occurs with respect to articles of furniture that might fall on the child, doors that might slam on his fingers, dirt that might make him sick, drafts, moisture, flame, heat, etc.—each is a source of danger. The average infant experiences all these natural defenses against hurtful objects and, whether he will "out-grow" or retain the fear of objects depends upon how much emotion is invested in the warning. The parents play a substantial role in the final liquidation of the fear. Normally, too, the fear or deep concern is related to conditions outside of the home. Inclement weather comes to be associated in the infant's mind with harm; later—vehicular traffic, other children; still later comes the fear of adults. To a greater or lesser extent, fear fans out from infancy onward till the close of life.

Some children are unusually sensitive to fears, responding with extraordinary emotions to them. This appears to be true among some, even though the parents train the child within the normal range of concern. In severe instances, which fortunately are relatively rare, little can be done by the parents or professional personnel to bring the fear within average boundaries. The child clings violently to the parent or parents and is at comparative ease with them. Some few are never favorably influenced by experiences. They go through the early grades of school being handed over directly by the parent to the teacher and back to the parent. Years later they are still employing the same method of moving from place to place. They are afraid to take a step alone and fear may be roused by one or more of a vast array of things in the environment, unless some sort of caretaker is with them, someone from whom they can get assurance that everything is safe. *Patients with such a deeply rooted fear that has remained unmodified by reasonable parental care are ordinarily very resistant to psychotherapy.*

It can be appreciated that the fears of infancy and childhood

can show various degrees of *fixation*, ranging from that just cited down to the very mild. The latter can usually be handled in a satisfactory way by parents who are themselves free from morbid fears. However, when the parent mainly responsible for bringing up the child implants fear in the child's mind, the future of the child is crippled to some degree. In developing this theme, we shall lay more emphasis upon the fear than upon accompanying phenomena, because the center of discussion in this chapter is the use to which fear as the prominent symptom is put. A "*fear*" *psycho-neurosis* is not basically different from other forms of *psycho-neuroses*, save that the symptom through which the unconscious complex releases its energies is different. The same complex, say, an Oedipus complex, may appear symptomatically in one person as a fear, in a second person as a compulsion, in a third as a delusion, in a fourth as a hallucination, in a fifth as a sick stomach. And, again the same cause can give rise to different symptoms.

If we stop for a moment of orientation, we can see that a given complex, let us assume it is a mother complex, may be normally resolved through environmental activities which serve to attract the emotions from the individual's inner mind to people and situations unrelated to the mother. Psychiatric patients as a group are unable to effect such a transfer of their emotions to the extent insuring healthy adaptation. They cling to the parents by some kind of subterfuge.

(1) The mildest form—it is really not much of a subterfuge—is to live on peacefully with the parents. In this case the individual is contented, conflicts are absent or mild, and everyone is happy.

(2) A second way of getting along is represented by constant bickering between the child and parents. The son or daughter quarrels and fights with the parents, or with one of them, most of the time. It may be a habitual defense against an Oedipus or Electra complex; if so, psychiatrists say that the son or daughter has a *character neurosis*, meaning that the energy of the complex is vented through character traits.

(3) A third method of "solving" the Oedipus complex (or any complex) is employed when the milder methods fail. Then the

energy is released through formal symptoms, which in the psychoneuroses are mainly expressed as anxiety, or conversion hysteria, or fear, or obsession and compulsion, or less frequently as melancholia.

In the full-blown schizophrenic patient the complex is commonly taken care of through delusions and hallucinations. The manic-depressive patient, in the manic stage, gives outright vent to both the emotions and the ideas, but in the depression stage, he is punished severely for his illicit unconscious impulses. The "psychopathic personality"—he will be described later—escapes awareness of the Oedipus drive in him by expending its energy in the form of direct and antisocial activity with others.

Psychiatry is the science of mental energy as it manifests itself first as instincts, later as emotions and feelings. The scientific study of psychiatry traces the course of mental energy from its source in the body through the several sections of the mind, from (a) the primitive, instinctual layer (the *Id*) to (b) that of body-mindedness (psychosomatism), to (c) mind-mindedness (narcissism), to (d) suigenderism, and finally to (e) altrigenderism. In this tracing of the path of mental energy, attention is given to that part played by the mental energy that comes from others also, particularly from the parents, for they are the most influential outside agencies in the life of the child. When, for one reason or another, an individual cannot successfully give vent to his mental energy in ways to suit himself and others, the energy remains pent-up within him, being attached perhaps mainly to experiences in the conscious part of his mind or perhaps mainly to those in the unconscious. The latter is made up of (a) experiences that are no longer useful to the individual, as well as of (b) experiences or impulses that he dare not know about. When the latter put on a drive for admission into consciousness they face opposition. The conflict is resolved by a troublesome compromise that is unsatisfactory to both sides, namely, by release of the complex through disguised and masked activity constituting symptoms. Fear is one of the manifestations of such a compromise.

It seems that such fear may have two major sources, the child

himself and the parents. Careful study is necessary to determine which exerts the more powerful influence, for the prospect of cure, depends in fair measure upon the relative weights of the two. The fear that is preponderantly inborn and instinctive and, through re-enforcement from the parents, gathers force as the infant grows up, requires long and painstaking treatment to insure even modest results, while that resulting largely from the parents is more likely to respond favorably. The time in the child's life at which fear is implanted also plays a role of much consequence, for it is the more amenable to treatment the later in life it appears.

A thirty-three-year-old man had for years been plagued with fears, the principal one being an agonizing fear that he had swallowed very tiny bits of glass. He spent hours and hours examining the rims of drinking glasses with a magnifying glass, in the certain dread that he was soon to die of the awful effects of minute particles of glass in his throat. Within recent months he had eaten barely enough to sustain himself because he was sure that particles of glass had gotten into the food at some stage of its preparation. He thoroughly washed every glass in the house directly after the maid had just spent her energies cleaning them exactly according to the specific directions he had given her. Then before each meal he repeated the ritual, never, however, with the feeling of satisfaction that the food was free from glass particles. Not only was he unconvinced that the glassware at home was without danger, but he was so beset with the belief about the preparation of food in restaurants being contaminated, that he ate very sparingly and with violent panic. It became so bad that the moment he swallowed a little food he inserted his finger in his throat to induce vomiting.

He was a very pathetic figure when he first visited the psychiatrist. He had barely enough energy to get to the office, perhaps more owing to fright than to the insufficient quantity of food he ate. He spoke in a low, almost inaudible tone and his general appearance was that of a terror-stricken supplicant, who could at times produce a make-believe grin.

As usual with such patients, he recounted that he had been brought up on fear, but a few years previously the fear of glass

particles began to grip him so violently that he could hardly carry on his professional work. Then the fears began to multiply in numberless directions, until they finally immobilized him as completely as any mechanical device could possibly do.

The vast majority of the fears were directly or indirectly connected with small objects, although the patient had lost sight of that fact. Because of his dread, he polished and washed all utensils used in eating. When he first began to do that, he could come to the point at which he felt that maybe the danger was reduced to a minimum, whereupon he would hastily bolt some food down. But then promptly, in the belief that the food contained dangerous particles, he would induce vomiting and follow it with a half hour or more of mouth washing. He could not eat in a restaurant or at the homes of friends. Eventually he could not eat in his own home with guests. But the fear was greatest when eating with his parents, particularly with his father.

The fear of swallowing tiny particles, he recalled, was first experienced in his own home in the presence of his parents. He was panicky throughout the time he thought meals were being prepared and the feat held him so thoroughly that little by little he supervised the preparation of the meal by minutely examining everything associated with food in the kitchen. The meal hour became a dreadful experience for all concerned with son frightened almost to the point of collapse, while mother and father humbly submitted to his every whim. They regarded him with great pity, but later, with his everlasting but ever-unsatisfying meticulousness, their pity grew mixed with irksomeness. Through supplication he appeased their vexations, adding what he considered scientific proof of the need for the safety measures he was employing. He profusely apologized for the concern he was creating in them, professing that he appreciated *he was making them suffer* as much as he was suffering, if not more.

This raises a very fundamental observation with respect to these and other psychiatric patients, quite apart from the diagnosis. The effects of psychiatric illnesses are seldom if ever confined to the patient alone in the sense that a physical disease is. The latter re-

stricts its alarm mainly to the patient with, of course, reasonable concern on the part of the parents. But, *an emotional illness reaches out to the parents*, if they are living, or into them as they are represented in the mind of the patient, whether they are living or not. To the normal anxiety of parents with a mentally sick son or daughter is added a still greater anxiety from him or her. Frequently the three are rendered helpless. Visitors to the house must literally be told who the sick one is, because, assuming that they had not seen the three before, they would be put to the task of separating the primary from the secondary ones. Indeed, it is not too uncommon to pick the patient as the healthiest of the three, because of the leadership that he assumes.

As a rule psychiatric patients dominate the household at some time of their illness. Some do perpetually, while others do so until the time they leave the house. And they dominate it often with the ruthlessness of a suave sadist. No one will have a deeper appreciation of the truth of this statement than the members of the household groaning under the yoke imposed by the psychiatric patient. The most reliable immediate clues to the general nature of an illness of this kind are to be seen in the great depth of emotions reigning between parents and child. The direct reason why some patients have to go away to a sanitarium or a rest home is often found not in the illness itself, but *in the intolerable inter-personal relationships issuing from it*. To those not familiar with situations of this kind, it may seem strange that a debilitating disorder can contain venom and malice, yet that combination is by no means rare.

The patient with the fear of small particles actually had his house at a standstill, save for the activities necessitated by his fears. As time went on he developed the same dread of small particles of dirt, in which he included bacteria. The fears all led to his mouth which was soon seen to be the pivotal point of his mental abnormality. He now controlled more than the kitchen and dining room, for his fear of dirt extended to all rooms of the house. Behind a veil of menace he begged his parents *never to enter his bedroom*. They were never told why, but they knew without any explana-

tion. *He feared that they would pollute his bedroom.* Until he was psychoanalyzed, he never realized the deeper meaning of the fear. Not only would they pollute his bedroom, but more specifically his mouth. It developed that the fear referred to his father. Son was afraid that father would cause thousands of tiny things to enter his mouth and gag and torture him.

Later, he became fearful of numbers, particularly the number twelve. The symptom never acquired the strength of the fear of tiny particles, but it modified his habits to a considerable degree. Of course, he had no inkling as to why he avoided twelve, no matter in what form it appeared. He went so far as to paste an opaque square over the twelfth of each month on the calendar. He omitted numbering the twelfth check in his check-book; when he reached the twelfth of the pills prescribed by his physician, he took two to make it "not twelve." During the analysis, twelve to him was one and two, "like the trinity" and then—with surprise: "like my own home."

He included pins in his fears, especially pins in his pyjamas. They, too, would go to his mouth and to avoid this dreadful possibility he searched and searched and searched the pyjamas for pins which, it is hardly necessary to say, he never found.

He was thrown into a violent panic, when he felt the edge of a gold crown covering one of his teeth. The crown had simply become roughened, but to him the dread of his life was realized. He was terribly alarmed, when he reasoned that he would have to go to a dentist, that a dentist "is in everybody's mouth" and therefore with his own everlasting fear of being infected, there was absolutely no way of escape. Surely now the man would put myriads of tiny organisms into the patient's mouth.

It was clear that this patient's fears were completely impermeable to reasoning. In this wise he was no different than any other psychiatric patient. Here was a college-trained man, whose professional career was the mouth. These patients know only too well the utter worthlessness of organic scientific facts from the standpoint of their symptoms. Reasoning with such facts is valueless. The gastroenterologist (intestinal and stomach specialist) who has trouble

of emotional origin (which he does not realize as such) in that part of the body is helpless in explaining away his symptoms with the clear-cut facts with which he daily treats his patients. The heart specialist with a heart neurosis is thoroughly 'unconvinced' by all the tests by which he concludes others have no organic heart disease. The psychiatrist with a neurosis cannot apply to himself what he knows about the emotions.

Our patient was first seen by the family physician, who prescribed sedatives, having satisfied himself that there was nothing organically wrong. Sedatives are invaluable remedies and have their place in the practice of medicine. *They are the weakest excuse yet devised for the treatment of an emotional disorder; physicians should prescribe sedatives only as a temporary expedient to tide a patient over a severe and urgent condition.* Too often sedatives are given, because the physician has no knowledge of how to treat an emotional disorder and cares still less. It is true that many doctors are too busy with their own specialty to be able to treat emotional disorders, but that does not justify their having a number of mental patients to whom they administer only sedatives. Unfortunately the patient, himself or herself, usually contributes to the physician's misfeasance, not only by being satisfied with the sedatives alone, but by making light of or resenting any survey of the reasons for the sedatives. *In the practice of psychiatry, sedation should be a last resort and, moreover, should be used for treatment of the patient's condition, not for the avoidance of treatment.*

However, with or without sedatives, the patient managed to keep up his professional activities, under great handicaps, to be sure, yet he carried on, as an armless man might do mechanical work with artificial limbs. His family physician later solemnly advised him to marry, a solution to which the patient's family agreed. Under the circumstances, he went from the frying-pan into the fire. From sedatives to marriage was a step from bad to worse. The patient solicited the interests of a young lady with whom he was in daily professional contact. Indeed, from time to time he had spoken to her about his being nervous and she encouraged him to tell her more. She was sympathetic to him and he often

said to himself in thinking over the situation that if he ever married he would like to have a girl like her, for she was just like a mother to him.

He courted her. But to say that he "courted" her is misleading. Details of the "wooing" showed that their connivings were almost exclusively on the basis of his neurosis. It was a patient-nurse or a son-mother relationship. He could not touch her, nor she him, lest he became infected. He eased her into that belief with his scientific facts, though it appeared that even without the facts she was agreeable to physical aloofness.

From the first day of marriage, their relationships were stormy. He quarreled violently with her, this man who was always so subdued and polite. His fears did not prevent him from pommeling her. He vented his spleen upon her, when there was no obvious cause whatsoever. Within a few weeks "she had me so nervous"—as he put it—that he decided to go a psychiatrist, to whom he emphasized how much worse off his wife had made him. "She did not understand me after we got married. How different she was to me before marriage." From a large number of facts it was obvious that just as soon as the new mother, for that was the light in which he conceived his wife, made herself available for sexual relations, he objected violently to her. In his antagonistic encounters with her, he rebuffed her for her two-faced attitude, charging her with play-acting the role of a kindly, maternal, solicitous woman before marriage and being mean and coarse after it. At his instance they parted within a few weeks after marriage.

His life history was a continuum of fear, combined with undue submission and antagonism simultaneously. His earliest recollections related to most intense jealousy towards his sister, born when he was five years old. Under the analysis, he finally uncovered most vivid scenes in which he was enraged at the newcomer, the arch rival for mother's affections. Unseen, he used to steal into the infant's room and squeeze her head with all his might. He repeatedly slapped and clubbed her. "The more she was agonized the greater the thrill I got. I sincerely hated her with all my might." Later when he took her out in a carriage, he purposely tipped the carriage

over on many occasions. He was always careful to explain to his mother how much he loved his baby sister and how scared he was whenever she was endangered.

Mother was fully convinced of his great devotion to her and she returned it in equal measure. Still, no matter how loving the two were, he harbored hate for her because she loved also his little sister. The hatred grew worse towards mother and sister. He found many opportunities for punishing his sister physically and mentally, but he never released hate upon the mother directly. She may have suspected it, however, because throughout his childhood she was often summoned to the kitchen to rescue the cook or a maid, who had been butted to the floor by the son, still punching away energetically. She said she often wondered when her turn would come to be so manhandled by him, since his hatred was expressed towards all adult women save her. He was described by his women teachers as "the meanest boy in school to his teachers," who felt fearful that some day the bitterness evident in his postures, gestures, and grimaces might be spent upon them.

He was an avid reader of torture stories. One of his favorite stories, which he read and re-read for several years, had to do with a pyromaniac who in one instance caused children to be burned to death. Horror stories in the newspapers were his delight, and in the psychoanalysis he recalled with seeming accuracy the details of cruelty, especially those relating to little girls, but not excluding the torture of grown-up women. All of this over the years was concealed behind a loving attitude towards his mother and an inordinate fear of punishment at the hands of boys and men.

He used to ingratiate himself with the toughest "kid" in the neighborhood as a guarantee that other boys would not fight with him. He had been brought up under an impetuous and pugnacious father, who had the reputation in the neighborhood of being "a little Napoleon." He emulated his father's aggression, but he directed it upon women, as he had so often seen his father do upon his mother.

He was, indeed, *the emotional replica of both his parents*, a form of personality organization that is not uncommon among psychi-

atric patients. Many of these patients are well aware of the feeling that they are not themselves. They say it very definitely, yet without professional assistance they are utterly unable to recognize who they are. Analysis almost invariably reveals that the controlling factors in them are derived from the parents, not in equal measure generally, but more from the one than from the other. This gives them the peculiar cast of bisexuality so often observed in them. They are neither male nor female but both—yet neither in their own right, so to speak. The patient knows clearly that as an entity, as one who thinks, acts, and feels for himself, as one who forms his own judgments, he is puny and incomplete. It gives him an intense feeling of smallness, often leading him to refer to himself as childish and immature.

In fact, our patient expressed that concept of himself when he said that, both mentally and physically, he was so weak that *he felt like a helpless girl*. He added that he was totally at the mercy of the physician, and his general behavior was not at all unlike that of a baby towards a parent. He asked that he be put to bed for a long rest, because he could not walk, talk, dress or feed himself.

While there were many fundamental defects in this man's emotional growth, the one that seemed to be nuclear was the female role that he was unwittingly living out through symptoms. He had so thoroughly identified himself with his mother that he was just like her. He grew up as a woman; he liked the role, yet he hated it. This *ambivalence* (coexistence of love and hate) was pronounced in him. Unconscious homosexuality was the outstanding force with which he had to contend. It was consciously and symbolically represented as a struggle against drinking in thousands of little things, which, as the analysis showed, were tiny, living things—"disgusting and sinful" spermatozoa.

There was only one thing in life that gave him unbounded pleasure, a practice that he had acquired in his youth. He would sit for hours at a time pressing his thumb against his nose, deriving, by means of this mannerism, a constant thrill from the pressure and from the odor accompanying it. He maintained that to him his nose was better than any friendship he had ever estab-

lished. "It's better than any love" was the way he put it and he cited many instances to show that he gave up appointments "with nice girls, too" to stay at home with his nose. The narcissistic value of his nose was intense.

His friends chided him constantly about his nose and his interest in it. "If you gave a girl half the attention that you give to your nose, you would be a great lover," is the way one of his friends summed up the situation. He smiled the comment away with the feeling that a man has the right to choose what he wants to love.

It enraged him to see others pick at their noses and on more than one occasion his judgment was so swayed by anger that he lectured strangers who were nose-picking. He did so with a measure of apology, which did not, however, abate his determination.

Within recent years he learned how to stimulate his nose without making it too obvious to others, for he was becoming embarrassed by the comments his friends made about the habit. Through constant practice he could move the muscles of the nose so as to get nearly the same thrill as he did by manipulation. But the nasal tic was no less prominent than the former activity. He then trained the cheek muscles to bring pressure on the nose, supplementing the action with the hand in a way to conceal from others what he was doing.

During the years his nose was examined by a number of specialists many of whom concluded that there was nothing wrong with it. There were others, though, who were certain he had an allergy in the region, for which he received extensive tests and treatments. Unfortunately they did not test his allergy to emotions, for they could have found the trouble there.

He also had an ocular tic that was very noticeable to others, but which was not at all bothersome to him. On the contrary, it was a real pleasure to him, because it meant that he was looking at his nose. He was able to converge the eyes and fix them upon the nose for a relatively long period.

Not until he began to be psychoanalyzed did he ever look behind the symptoms for a possible meaning. As happens with so many

patients he was amazed at the simplicity of some of the symptoms. After he had given the history of his nose and had brought all the facts together, something he had never done before, it was clear to him that the nose was the only part of his body that gave him pleasure. As he said, it gave him a thrill and relaxed him. Furthermore, he volunteered the obvious conclusion that the value he attributed to the nose was the equivalent of that given to the male organ. Then he added, wholly spontaneously, that for years he had noticed that when his nose was excited his genitals were not and vice versa.

It was an interesting point, upon which he eventually came to place great emphasis, that only in one situation was he free from nose and eye symptoms, namely, when he was with his parents. Why was it that he agonized them with all the rest of his troubles, but never with his nose? Why was the nose completely concealed from them, as thoroughly hidden, if not more so, than the more intimate organ of his body? He was able to see the meaning of the nose with respect to his parents, but shortly thereafter he began to fear that he was about to develop cancer there (in the nose, in the penis), because cancer comes through friction and had he not rubbed and pressed his nose for years? He feared the nose would become diseased and wear away. Then he would not have a nose. It was some time before there dawned upon him a connection between an organ improperly and illicitly used and the loss of the organ. The fear of cancer was but a disguised fear of castration.

Fear of castration is rooted in the biology of the human race. It is ages old and has been represented in the folklore of peoples from the time of recorded history. The classical version, known best to us, appears in Sophocles' *Oedipus Rex*. As a punishment for having, without his knowledge, killed his father, married his mother and had children by her, Oedipus castrated himself. In a later recounting of the story, he gouged out his eyeballs or killed himself. As the essence of the tale is dramatized by our patient, he loses his nose, that is, his penis, through cancer. Not infrequently the fate of the modern Oedipus appears in less severe form, that is, as sexual impotence.

The mouth symptoms were handled by him in a similar way. When all the facts were gathered and summarized—and it took a long time to get them in and topically arranged—the meaning of the oral troubles slowly became clear to him. The unraveling of the history of the mouth led away from glass and bacteria and into his personal relationships with people, first with friends, then teachers, then back into his own home, where it received considerable elaboration with respect to his parents. It should be stressed that *it is a gross error on the part of the psychoanalyst to direct the patient's trend of thought. Leave the patient alone; let him keep talking; he will eventually provide all the facts necessary for complete understanding of the situation by both the patient and the psychiatrist.*

Then, after he has produced a volume of talk, make a review with him of the leading topics and the interest he devoted to each of them. It may be observed, as it was in this instance, that he spent about ten per cent of his time in describing the symptoms proper, that about thirty per cent was devoted to discussions on his nose and mouth as they related to other people, while the bulk of the conversation was built around his parents. This is a simple summary of the analyst's record, founded on the unabridged material provided by the patient.

The psychoanalysis of this particular patient extended over some five hundred sessions of fifty minutes each. His was an especially severe condition, which had existed in one form or another since his early childhood. It was so much a part of him that it would not be incorrect to say that it was he. He grew up as a *case* almost in a literal sense, for, aside from the use of his intelligence, first in his student years, later in his professional life, he was a case of pathology of the mind.

Now, three years after the termination of treatment, he is evidently better than he was. He steadily practices at his profession, lives moderately comfortably with his wife, is neither too aggressive nor too submissive, but he is not cured. It is not easy to designate the degree of his improvement. Perhaps, it may be understood as about a seventy-five per cent improvement.

The course of psychotherapy in an instance of this kind may be very generally summarized in the following paragraphs.

(1) Depending upon the extent of the symptoms, the first part of any psychoanalysis is usually taken up with a detailed account of the origin and development of each symptom, emphasis being placed also upon conditions prevailing in the patient's life at the time of the appearance of the symptoms and their subsequent relation, if any, to the symptoms. It must be kept in mind that *psychiatric symptoms almost always have intimate connections with the people to whom the patient is or has been close.*

Usually, at first, the patient describes his symptoms as isolated troubles, for which he can ascribe no cause. Or, he may believe the cause to be a physical disease or disorder of some sort.

(2) As the history is uncovered, *the patient begins to get a little inkling of the possibility of causes that he had not suspected*; this part of the analysis is alarming to him, because he is moving in the direction of the very topics that he would most avoid, the ones that had been so completely hidden by the symptoms. He is puzzled. Shall he continue to reveal, thus exposing himself to a danger that seems worse than the symptoms? Psychoanalysis is sharper than the surgeon's knife. Let us assume that the patient has the courage to go ahead, not unarmed, however.

(3) He fortifies himself in many ways, each of which is commonly known as *resistance*. It should not be forgotten that *the patient needs the protection that resistance gives, and that need should be respected by the psychiatrist. Save through a mild and sincere interest in getting at the facts, one should never try to break down the patient's reluctance to elaborate upon a topic.* When he stops talking about a topic, it is a warning to him that he is not prepared to receive the information being withheld.

Resistance may be shown in a variety of ways. Ceasing to discuss a theme further is one of the ways. Constant insistence that the cause is physical, when that cause has been amply ruled out, is another. Refusal or inability to talk at all, or very meagerly, is still another. So are such actions as failure to keep appointments with the psychiatrist, constant bickering, the use of general terms

in psychiatry in place of specific facts of the patient's life, and the compulsion to relate an experience in such great detail that the core of the experience is lost in the details.

Rationalization is another form of resistance. It means that the patient believes that his explanation is thoroughly plausible, though there may be (not to him, however) no soundness in the point of view he is trying to establish. A very simple form of rationalization is seen when a patient, asked to explain why he never had a girl friend, expresses the implicit belief that it was because he and his family moved almost every other year from one neighborhood to another.

Deserving of special note also is the type of resistance observed when a patient, having given a modicum of information, keeps insisting that the psychiatrist explain fully the deeper meaning of the information. If the psychiatrist falls into the error of providing such information, the patient can do either one, or perhaps both of two things with it.

(a) He can accept it wholeheartedly, which means that he gets no therapeutic value out of it, because the explanation strikes only the patient's intelligence, not the emotions which it should. The psychiatrist who calls for faith may get it, but that is all the patient gets, too. Faith has its place, but it is not in psychiatric *treatment*. *What the patient needs is intellectual and emotional insight, that is, understanding of the relationship between the symptoms and their real causes, as those causes are seen to come from his life, not from theoretical interpretations.*

(b) The patient can reject the psychiatrist's explanation. If he does, he may courteously acknowledge the training and experience that the psychiatrist has had, but, as far as the patient is concerned, the explanations are of no help to him.

(4) What generally occurs in a successful psychoanalysis is a *simultaneous exposure of the complexes to which the symptoms are related and of the emotions bound up in the complexes*. The accomplishment of this aim almost invariably depends upon the recognition and management of the devious methods used by the mind to release the energy of unconscious complexes from the

sphere of the unconscious. The unconscious does not easily reveal its contents. On the contrary, it persists in holding on to all it possesses. Then, too, it is a fact that the conscious self resists knowing what is down in the unconscious.

But the energy of the unconscious must find its way into consciousness, for the simple reason that it starts in the unconscious and naturally flows towards and into the conscious. It is known, however, that the energy does not necessarily have to reach consciousness in the company of the ideas, experiences or impulses which it had in the unconscious. A simple example may make this clear. The sexual impulse and its energy, arising from the instinctual sphere (the *Id*), move further on, where they encounter the inner conscience (the *super-ego*). The latter resents the sexual impulse passing through it, but is willing to let the energy of the impulse go on its way. Energy, however, cannot travel alone, so to speak. It must be carried along, either by ideas or by organs of the body. Hence, at the borderline of the *super-ego* it leaves the sexual impulse, going out into consciousness in the company of one or more various vehicles. For example, the energy may go over to the muscular system and be used up in strenuous exercises. The sexual energy may be spent in reading or studying.

) There are many so-called vehicles that may serve to transport energy which has been taken from its original source in the unconscious. This shifting of energy from one mode of transportation to another involves what are called *mental mechanisms*. They are the means by which instinctual energy of the unconscious manages to escape from the unconscious out into the open without detection, except by those who are trained to recognize the disguises that the energy puts on.

What is the purpose of all this secrecy? The unconscious harbors impulses to which neither the individual nor the society in which he lives dares give unbridled freedom. Man's own moral sense together with the laws under which he exists check as well as they can the freedom of instinctual love and hate, for if those two instincts were to roam society without restriction and *repression* the society in which we live would be reduced to primordial chaos.

The reason why we must compel man's instincts to meet his personal and environmental needs, that is to conform to what might be called our mores, is very simple—personal and social protection and safety. We see what happens when an individual acts with uncurtailed freedom and when man has no respect for the life and property of others. The individual is apprehended as promptly as possible and punished for his criminal actions. This is little more than saying that man's inner self is essentially a criminal against which the severest restrictions must be erected. The first source of restriction is within man himself, constituting the code of morals called the *super-ego*, the inner conscience, incorporated in his mind through early parental training.

What we call *mental mechanisms*, therefore, might also be called *the personal laws governing the instincts* in contradistinction to the *social laws* serving the same purpose. A comprehension of these personal laws is necessary on the part of both the patient and the psychiatrist for successful psychotherapy.

For purposes of exemplifying the various mental mechanisms from the standpoint of their *actual occurrence in patients*, rather than as isolated, technical laws, they have been defined and described in many sections of this book. Bringing all of them under a single heading, they are as follows. The enforcement of many of these laws is often shared by factors in the conscious part of the mind as well as by those in the unconscious. The laws are to be construed as *measures enacted by the mind for the protection of the conscious mind against illicit acts on the part of the instincts*, illicit, sometimes only from the point of view of the individual himself, sometimes only from that of society, sometimes of both the individual and society.

LAWS OF THE MIND

I. Enacted by the conscious mind

Resistance through the medium of

1. Mutism or failure to speak
2. Evasion by irrelevant speech

3. Hostility
4. Distraction to unrelated objects
5. Intellectual, but not emotional, acceptance
6. Rationalization
7. Reaction-formation

II. Enacted by the unconscious mind

- A. Transference
- B. Identification
- C. Repression
- D. Sublimation
- E. Projection
- F. Introjection
- G. Conversion
- H. Displacement
- I. Condensation
- J. Isolation
- K. "Undoing"
- L. Symbolization
- M. Dreaming
- N. Unconscious phantasy

As the patient gradually reviews the events of his past life, he comes upon many to which for one reason or another he may have reacted in a way that he then thought was correct. When he surveys the older experiences from his new and comparatively safe position, that is, in the physician's office, he is relatively free to size up the situation and to live out the emotions as he now realizes he would have done had he not felt under strain. This is merely a duplication of experiences that many of us have, namely, because of fear, we act and feel towards a person just the opposite of the way we feel deep down within ourselves. Then, when we are away from that person, and recount the event to another, we "cut loose" the suppressed feelings in a tirade of hostility. The psychotherapist says that the patient is *abreacting* the original scene as it would have been, had he "cut loose" in the first instance.

There is a second probability also. The patient may have reacted "instinctively" to an experience in the first place and later, out of

a sense of guilt or fear, repressed the emotions, which may subsequently be re-enacted during psychotherapy.

A third possible way of handling a tense situation which we do not want to repeat is to detach the emotions from their original experiences and live them out upon other people or circumstances. When we do that, we do not realize that the emotions are merely being lived out upon someone who actually has no connection with or responsibility for these emotions. We may appreciate the fact that the substitute for the original person does not merit the excessive emotions which we impose upon him, yet that is often all that we know.

One of the techniques of psychoanalysis consists in guiding the patient's original emotions through the various situations in life which served as substitutes for the original scene, tracing the emotions back until they meet with the original scene, which is then lived out, reacted to, *abreacted* to as they were or might have been.

The whole array of mental symptoms may be looked upon as substitutive "objects" or phenomena which serve the double purpose of (1) drawing the pent-up feelings out of the unconscious and (2) concealing from the patient the source and motive of the emotions. Psychiatric symptoms are but symbols of unconscious turmoil and the process is called *symbolization*. Fear is but one of the symbols or symptoms.

However, the basic *mental* processes that give rise to one or more symbols and the general method of tracing the meaning of the symbols back to its original source are not essentially different in fears than they are in obsessions, compulsions, conversion phenomena, delusions, hallucinations, etc. Until the doctrines of psychoanalysis became as well established as they are today, mental symptoms seemed to be almost infinite in number and even more perplexing as regards their causes. Of course, there are many mental problems the nature of which is still not understood. Yet, much is understood and that part of it which we do know can be reduced to simple terms or concepts within the grasp of the average individual. The basic facts are these:

1. In its own particular way, the human mind is an artfully and

ingeniously organized set of impulses, experiences and ideas. Its foundations are rooted in the deep past of mankind. Like organs of the body, the mind has ancestry, made up of instinctual patterns extending back into the habits of primordial man. The instinctual patterns have great driving force, which, as man became civilized, had to be controlled to make it conform with the laws and mores of the culture to which it was exposed. This instinctual driving force is still very powerful, though in a civilized community the majority of individuals have learned how to curb it and to use it. *A patient with a mental disorder is one who for one or more of several reasons cannot adequately control the instinctual drives within him.*

2. The instinctual forces, present at birth, are gradually molded by the people and circumstances with which the forces come in contact. In our present society, the responsibility for the shaping of the instinctual powers of the child rests pre-eminently with parents until the population at large takes over the duty in the form of organic laws. All the law asks is that the parents bring up the child to conform with the mandates of the state.

That is often a very difficult task, more so because the child and the parents are given great latitude as regards the *emotions*, or, in other words, forces. There are no statutory laws with respect to a large number of emotional relationships which can be established between parents and their children. This is but another way of saying that *there are no laws at all for the proper governing of parents and children in one of the most fundamental requisites for living, namely, emotional harmony.* There are only unwritten codes of discipline. What makes this dangerous is that even the unwritten codes are to a greater or lesser extent drawn up by each individual in accordance with *his or her own* special point of view. Every parent is a law unto himself, an emotional law, so to speak, a law that is put in command of the child's most dynamic possession, its instincts.

3. The outcome of *the interaction of parental authority and the child's self-assertion, its instincts*, is usually reflected in the way the child adapts itself to late childhood, adolescence, and adulthood.

a. Sometimes the instinctual forces of the child and of the parents are well handled, meeting the requirements of home and environmental harmony.

b. Sometimes the instinctual forces of the child are unmanageable or only partly controllable.

c. Sometimes those of one or both parents gain and maintain supremacy.

4. A weakening of the moral, cultural, conscious forces in any one of the three parties is a strengthening of the instinctual forces, the results of which may be represented emotionally by:

a. A character neurosis

b. A psychoneurosis

c. A psychosis

It may be said as a generality that *the greater the force of the instincts, the more severe the mental disorder.*

5. When the moral conscience of the individual is weak, the instinctual forces may be directly lived out by the individual onto people in the environment. This form of behavior is antisocial, criminalistic and is called *psychopathic personality*.

6. When moral conscience is strong, yet not strong enough to control the instinctual forces, those forces may gain control over the individual by one or more substitutive ways, which, as a group, are called psychiatric disorders.

The instincts can and do employ subterfuges to act for them. Such subterfuges are supposed body diseases (conversion phenomena), fears, obsessions, compulsions, delusions, hallucinations, etc. The reason behind what is called the "choice" of a symptom—why one individual reacts with fear, another with body symptoms, a third with delusions—is still not known.

7. An Oedipus complex, or any complex for that matter, may be represented psychiatrically by (a) mild and general nervousness, appearing as emotional instability, called a character neurosis; (b) any one of the psychoneuroses; (c) any one of the psychoses; (d) by overt antisocial acts, as in psychopathic personality.

8. Psychotherapy serves two general functions.

a. *Prevention.* Obviously the prevention of mental disorders

should be the keynote of psychotherapy. Its purpose is to lessen the impact of the instinctual drives as they are first encountered in the child's associations with its parents and later with others. *The education of parents appears to be of uppermost significance in the control of mental disorders.* This means that the parents, *first*, should be familiar with the manifestations of their own instincts and know how to direct them into the environment in ways acceptable to others and themselves; *second*, should be trained in the understanding and social management of the child's instinctual urges.

b. *Cure.* The general process in the psychotherapy of a mental disorder consists in a patient's gradual tracing back of the ideas and emotions, *first*, as they appear in the form of symptoms, *second*, as they originally appeared in the mind of the child. This means that mental energy is released from its early instinctual attachments and is free to go to higher forms of adaptation.

Cure is accomplished when, with the aid of the physician, the patient is able to understand and overcome the many "tricks" of the mind known as mental mechanisms, such as transference, identification, projection, dreaming, etc.

Obsessions and Compulsions

Before going directly into the question of obsessions and compulsions, it seems desirable, from the clinical point of view, to make a few remarks about heredity—for purposes of establishing a point of view that is frequently overlooked. However important heredity may be, it certainly has not gained the distinction credited to it by the man in the street, who usually assumes that most psychiatric states are inborn. To know just what role heredity plays would be of great value, but the absence of that information should not give license to ascribe most mental states to it. We know reasonably well what the environment, meaning in the main the parents, means to the growing child.

That children emulate their parents, some to a greater, some to a lesser extent, is a well-known observation. When the good qualities are emulated everyone readily assents that the child has adopted the parents' habits, that is, that the habits are acquired. Heredity is given secondary consideration, if any. But for the acquisition of unfavorable or bad traits, there seems to be a different explanation—heredity. This is true in general. It is most apt to be true when the child imitates the symptoms of a parent's illness, especially when the imitation is clothed in the symptoms of "nervousness."

The meaning of the term *heredity*, it seems, needs definition. To the popular mind it means the transmission of mental and physical traits from parents to offspring. The idea may be assumed to go back to the grandparents. But, there is a far greater and, perhaps, more influential hereditary set of factors than the parents or grandparents, namely, mankind in general. Man is reproduced

in the likeness of man, both from the mental and physical viewpoints. There is the *racial* as well as the *parental man in us*.

Thus far in the evolution of psychiatry, we seem to be far more successful in the management of these two aspects of heredity, not as such, however, but as their forces are made available to us in the form of experiences in the environment. Maybe we are treating results, not ultimate causes. It seems that way.

The influences of what may be called parental heredity, whatever they may be, and undoubtedly they play a role, cannot be well differentiated as yet.

The most generally approved method is to concentrate psychiatric treatment on whatever can be gleaned from the patient's mind, without particular concern as to its origin, whether it be hereditary or later acquired.

In order to give some elementary orientation for differentiating hereditary from acquired symptoms, within the range of our limited knowledge, we shall first summarize the features of a family situation that seem to throw some light on the question.

Just why some patients express their troubles with physical symptoms, while others do so by way of fears, and still others with obsessions and compulsions is a question still awaiting an answer. The fact is, however, that they do. The same trouble, for example, inability to grow out normally from the family circle, may be worked out in one of several ways. It does not seem to meet all points in the problem to believe that the patterns of living laid down in the child's mind by the parents are the only cause. It even may be not improbable that there exists a strong *potentiality for undue influence* of the parents, a potentiality that evidently is already present before the parents really exert their pressure upon the child. We are heartened, however, by the opinion of specialists in the study of prenatal conditions that the fact that a trait is hereditary does not at all mean that it is necessarily unalterable. This point is worth being emphasized repeatedly, because the average man still thinks the term "hereditary" means that the trait will go on unchanged and unchangeable till the end of one's life. It is not so and it certainly is not so with respect to mental character-

istics. Patients who contend that they are destined to go through life mentally distorted, because their mother or father was that way, are not justified in their point of view, for the mere reason of their having overlooked the fact that their firm conclusion is often based on the psychology of the underlying urge to be like the parent, even in sickness. What they really are saying is that children must always be like the parents.

An example may make this point clear. A girl of eighteen grew up in such close relationship with her father that she openly vowed that there could never be another man in her life. Through childhood and adolescence she kept the vow to the letter. She was an active, energetic young lady, who spread her interests in many directions, but never for a man other than her father. She was attractive both physically and intellectually, and many young men sought recognition from her, but she knew how to parry their overtures with the minimum of disappointment to them. It was no secret to her or to anyone that her father was her beau.

She was sweet to her mother also, too sweet—indeed, she was cordial in the same way that one is to a dangerous rival who can be conquered only by appeasement. She was a little mother from the time that she was able to do things about the house. By the time she was eight or nine years old, she had already taken over an unusual amount of household duties. It was not realized, however, that there were two essential reasons why she did so. In the first place, she gained high esteem from her parents for being so helpful, and the esteem that came from the father counted most. Secondly, knowing that she was usurping mother's place, she was happy to repay mother by doing so much housework. Of this she was conscious; so was she of the feeling she had from time to time that she was unfair to her mother. *Her feeling of guilt grew deeper, because mother adored her and was always looking for dainty things for her. Daughter was glad to have such attention from mother, yet nothing seemed to dispel the remorse which she secretly entertained, and which grew with the years, intensified by dreams of her mother's death. There were several other "little" but exceedingly important happenings.*

On one occasion mother said she was too tired to go shopping in the neighborhood with daughter, yet she finally consented. While out, mother stumbled, and sprained her ankle. Daughter thereupon went into a state of intense anxiety, with self-reproaches that stamped her condition as very abnormal. At the time of the accident, she was so disturbed, so "hysterical" that she did nothing to help the mother and almost all of the passers-by's attention went to the daughter. *Anyone familiar with the workings of the mind could have surmised why daughter was unable to assist; some people get sick at the "oddest" time!*

When the daughter was sixteen years old, it was and it was not of psychological advantage to her that her mother began to suffer from high blood pressure and was ordered to rest by her physician. Daughter's anxiety and oversolicitude steadily increased, for she was now assuming more responsibility for the care of the household and of father.

She was becoming confused and complained she could not remember the things she should do. It was noticeable that her work around the house was getting more and more out of hand. The harder she tried, the more completely she failed. She could not have two masters, the one her (not wholly) unconscious, egging on to get rid of the mother, and she and father would be together and alone; the other was the sense of guilt prompting her to be honest to her mother and father, to do the things that any loyal daughter would do under the circumstances.

Hardly a year later, mother was stricken with paralysis of one side of the body and could no longer make her needs known clearly. The physician shook his head in a manner betokening hopelessness. To daughter it meant that soon the household, including the father, would be hers; but it was a horrifying inheritance to come into. Within a week daughter had developed symptoms strikingly similar to the mother's. The family doctor immediately had daughter taken to a hospital where he promptly administered the best known treatments for paralysis of organic origin.

Because he knows all these preliminary details, which the doctor did not know, the reader is apt to feel provoked with the doctor. In

truth he should not, for the physician was faced with the possibility of two organic patients in the home and he was taking a smaller chance by first assuming that daughter's condition was due to a brain disorder, and he believed she suffered from the same condition as the mother. He could have found the real cause, if he had known how to look for it. Within a few days daughter was so insistent upon going home that she sat over the edge of the bed quarreling with her physician, then walked over to a chair, sat down, stamped her feet and waved her arms threateningly. Without knowing it, she was making the physician her own father, as if he were to blame for all that was happening and about to happen. When a similar scene took place the next day, the physician made up his mind to retire in favor of another doctor. But, the daughter did not want him to leave. She insisted that he stay on the case, that he take care of her mother; she was very emphatic about that. She was equally emphatic that he could not handle her. Doctors are not always treated as doctors.

The mental aspects of the daughter's condition began to take priority over the organic and soon she came under psychiatric care. She made good recovery from her illness, not merely from her symptoms, but particularly from the mental causes, the family situation.

The reason for recounting this condition lay in the determined opinion of the members of the family and the physician that the patient was suffering from a family disease, since the history demonstrated that several had suffered strokes. The facts showed that the patient had had *an emotional stroke, something entirely different in cause, effect and outcome from the organic kind.* It is noteworthy how frequently heredity is erroneously blamed for an illness, when imitation of a parent's symptoms is responsible for it.

From experience it seems that the foregoing distinction needs to be kept in mind especially with regard to the question of the origin and development of obsessions and compulsions, for very often heredity is considered their cause and that conclusion is too frequently a deterrent to treatment. It re-enforces the patient's other defenses against revealing the real truth.

An *obsession* is defined as *an idea heavily charged with emotion which forces itself upon the patient's mind and cannot be reasoned away*. Furthermore, it is an idea extremely troublesome, because it *compels* the individual's attention to the exclusion of more immediate and pleasant thoughts. It may so preoccupy him that he can no longer perform his daily tasks or engage in his usual diversions. *A morbid obsession is always detrimental to the mental activity of a psychoneurotic individual, but ordinarily is not so to psychotic patients.*

Obsessions may be associated with abstruse matters. These are called *intellectual obsessions* and include constant preoccupation with such questions as: why was I born, why am I living, where shall I go after this life? The patient is never able to answer these obsessions with any degree of satisfaction. He simply never comes to know the reason. He is always wrapped in doubt and anxiety (if he is psychoneurotic). Why do things exist? What is time? "When a man asks me what time it is, I am immediately flooded with a barrage of metaphysical concepts of time and I have to feel that I have answered him with metaphysical doubts, while I am fully automatic in pulling out my watch." "In fact," adds the patient, "in all respects I am but an automaton."

Analysis shows that *obsessions serve the same general purpose as other symptoms—to prevent the individual from knowing the nature of his underlying troubles*. The same effect is accomplished through what are known as *inhibiting obsessions*, involving doubts, scruples, fears.

More frequently than not *obsessions compel action* other than thinking. They are then called *impulsive obsessions or compulsions*. Examples of these are the various so-called manias, such as the mania to count (*arithmomania*), to drink (*dipsomania*), to steal (*kleptomania*), to set fire to (*pyromania*), to repeat names (*onomatomania*).

A twenty-three-year-old man, quick of thought and action, stepped briskly into the physician's office and began to relate his troubles. It was evident that he was anxious about completing the full account in one short session, though he said that his whole life

was off center. The compulsion to talk and talk was clearly an effort to prevent other things from entering his mind, but obviously he was not succeeding very well. The conversation started with remarks on the nature of his work, his constant application to it, his successes in it; amid great pressure, it shifted to a rapid discussion of his courtship, marriage, and fatherhood. He talked as if he were not listening to himself. He just wanted to shake it off, as one, not daring to look at it, shakes off a cockroach, violently and with a feeling of loathing.

Meanwhile he kept moving restlessly, trying to conceal repetitious movements which progressively distracted him, until he finally gave in to them. In a spirit of embarrassed resignation, he explained that he had the irresistible impulse to think and to act out everything three times. He was struggling with it at the moment, trying not to surrender to it, but would the physician mind if he did, whereupon he repeated the last question three times, then moved a note-pad three times, took a pen from his pocket and replaced it three times, and performed other acts in series of threes until he finally gained a split second of relaxation. He was in a state of intense *anxiety*, which he attempted to relieve by quickly resuming an account of his life. But the compulsions overwhelmed him again. At the end of an hour he appeared exhausted and said that he was, yet, he added that for the first time in years he sensed that there was an element of relief. He left the office after making an appointment to come again.

He was a clean-cut young man, giving the impression of honesty and fairness. A warm frankness occasionally pierced his compulsions, as if to say that he was not begging for help, but he needed it in order to gain some control of himself. Obsessions and compulsions were dominating his life completely.

In what is to follow about this young man, attention is invited to his psychological background. In the two generations preceding him, male members of the family were obscured and dominated by women, jealous of masculinity, who did all they could, first, to belittle men, and second, to be better men than their husbands. It will be noted that our patient was rigidly brought up to be like

a woman, in fact, to be like his mother and grandmother. Unfortunately he was so pliant a tool in his mother's hands that she set the course for his instincts to follow.

His mother was a disappointed woman and had seen her own mother (i.e., the patient's grandmother) try for years to make her husband (i.e., the patient's grandfather) a successful business-man, though it was obvious that she took over full control herself, leaving the grandfather in the role of an apprentice, a position he inwardly resented, though he pretended obedience. The patient's mother was imbued with the same idea of doing something big in life and, in childhood, forsook the usual play and fun of a child in favor of hard and efficient work, being trained in that direction very energetically by her mother. The patient's grandmother and mother held long earnest conferences on the question of forging ahead. Success was their goal of living measured in terms of lucky business strokes and financial returns. There was no time, they agreed, for the idle ways of living in which most people indulged. Hence, they never were given to periods of relaxation, and the patient's mother never had a childhood in the usual meaning of that word.

The patient's mother had been trained to watch carefully for business signs, such as the probable influence of changes in politics, labor conditions, new legislation, etc., upon their little business. She learned to place meaning upon this and that social trend, reinforcing her guesses with a variety of superstitions culled from folklore and pamphlets on astrology. It was obvious that idolatrous devotion to the stars superseded her business interests.

The excessive niceties by which she lived were gradually transformed into obsessions and compulsions, resulting in progressive inaptitude in matters of business. Gradually she began to blame her father, as her mother had done before, for their failures, and like her mother, she took a strong stand against men. The patient's grandmother and mother held tenaciously to the belief that men were inferior to women and therefore should be led by women. Basically each was latently homosexual. Had they had any leaning towards socializing their homosexuality, they could have tried to

start a movement for a matriarchy, for in their own little home they became fanatical on the doctrine of woman's superiority.

As the patient's mother grew through adolescence, abandoning all semblance of effeminacy and driving forward in protest against masculinity, she became more resolute in her determination to get ahead of men. In so doing she became a man herself, more, however, in her beliefs than in accomplishments. She, who had never given love to her father, nor received it from him, and entered adulthood with men as her rivals—she, was going to gain control over those whom she did not know personally, with whom she had had no essential human experience. She had the psychology of a woman whose childhood was an emotional vacuum from the standpoint of interpersonal relations, save those that were coldly imposed upon her by a masculine mother. Her instincts were subjugated to the drive for supremacy and power.

She finally was resigned to the uselessness, as she expressed it, of building up her father to business heights. All that she had done in the matter of purchasing goods for the store, of keeping books, of setting up policies of salesmanship, had come to naught. And, the impulse to get closer and closer to her father, even though it took the guise of business grew steadily upon her and one could see also that her yearning was losing the business aspect in favor of little personal reactions that had a human touch about them.

When her father was sick, for instance, she became a nurse to him. She began to realize that he was a human being, and that she, too, was one. On that occasion they had a heart-to-heart talk about the kind of life they were leading, how empty it was, how unnecessarily cold. Her father sadly told her of the many times he had tried to be a husband and a father, but he had always had to give way to his wife's concentration upon their finances. He tried to get daughter to recall the occasions when he wanted to be with her, to take her out for walks, to laugh and play with her, to share feelings with her, but her mother always led him away from such "unprofitable" ways.

They (patient's mother and her father) were afraid to carry on such conversations with each other and they had to look for

secret situations under which to vent their intimate feelings. The patient's grandfather was getting elderly and his daughter was already twenty-four years old before they had come that close to each other. Father related how he yearned to be a part of her life, for he knew that she was unhappy in her stoicism.

The patient's grandmother soon realized that her husband and daughter were spending time together in personal outpourings and she openly charged them with collusion against her. Disagreements sharpened and rivalries became intense. Daughter tried to assuage both. The nature within, which had been submerged all the years, impelled her towards her father, while her training kept her to her mother. She tried to obey both inclinations by recourse to the superstitions which she knew now by rote, and she believed more closely than ever in the prophecies of her horoscope.

Uneasiness led to turmoil, which she finally concluded could be solved only by marriage. She rationalized that she should marry, though she knew that she was incapable of giving or receiving love. Her mother had assured her of that earlier in life and was now repeating it with greater fervor and emphasis. In spite of her mother's pressure to prevent it, daughter married. The courtship was brief and formal. Her husband, our patient's father, fifteen years her senior, was a mild-mannered person with only a token of success. The marriage lasted about one and one-half years or until the time that she had a baby, a boy, the patient in our story. Then she discarded her husband, because, as she said, it seemed to her that he had merely looked for someone to support him.

This was the background, then, of the patient with obsessions and compulsions. His mother was essentially a misanthrope who hated men because of their supposed inferiority to women. Nor was she any more kindly disposed to women who did not strive to advance woman's position in the social order. She was neither man nor woman, but both. She was an epitome of poorly rewarded success. During her pregnancy she planned the life of the coming child along lines of her own growth, allowing no quarter for the qualities of human nature. She had never had the opportunity of controlling a man from his earliest years, but now that it was pre-

sented to her she was certain of success. She could not fail, she thought.

She trained the infant boy with the same ardor with which she had schooled herself to forego the pleasures of living. She read a number of books on child psychology, read them from the point of view of bolstering her own ideas rather than of finding out what others had been taught by experiences. To her the child was a precious chattel, a piece of property to be carefully handled in order to insure the correct outcome of her plans. *Clearly, it was her success, not the boy's that was at stake.* The whole scheme was but a subtle device, *via her son, to grow up as a male in keeping with her latent homosexuality.*

Without trying to facilitate the natural laws of growth, yet being impatient with their slowness, she rushed each new phase, as if she were dealing with an article in the process of manufacture. Weaning was something to her to be quickly gone through with, and by so doing she marred the child's emotional life by withdrawing stimuli from the mouth too prematurely. It was not until years later that she realized why her infant son had been so petulant. When he cried because the breast had been withdrawn from him before he was satisfied, she was very rigid in her demand for obedience. She was determined she was not going to have a spoiled child.

After each feeding he was promptly put into his crib; she left his room, and he had to cry himself to sleep. There was not a vestige of love from the mother, but she did not tell her story that way. She maintained that no mother ever worked more diligently to bring up a child properly. She reasoned that when an infant is brought up on pleasure, it is not long before he has to be disillusioned and she wished to minimize this inevitable shock as much as possible.

She gained his obedience by short, simple orders. He could have no wishes of his own, save those that mother would approve. As he reflected back from his twenty-third year—by the time he was six or seven years old, he had been looking only for those things to which mother would give approval. There was very little evidence that he had thoughts of his own.

As soon as mother could do so, she taught the boy to read and count. She was proud to relate the ease with which he grasped what she was teaching him. If there was any admiration of him it went to his accomplishments, not to him as a living being. That fact was indelibly fixed upon him, so deeply that until his psychoanalysis he had never put himself forward. His intelligence was his only capital. Fortunately, he had plenty of that and it stood him in good stead, until he began to develop nervousness at the age of twenty-one.

From the earliest possible moment until he entered school, his home was a classroom, with mother the teacher. Grandmother took over the responsibilities as a substitute teacher, later, on occasions when mother took care of the business. His intellectual progress was "remarkable." But, there was no play or fun; there was no infancy from the emotional point of view.

Because no other children came into his life, he did not feel sensitive about his long curls and dresses, until he entered school at the age of six. Even then it took him a long time to realize why other youngsters made fun of him. When he knew clearly why it was, he dared to ask his mother to let him dress like other boys, a request that he often meekly repeated before it was granted. With great reluctance his mother acceded to his schoolteacher's expostulations.

He was the typical school prodigy. He had been so well-trained in scholarship and obedience that for years he failed to envy the boys who played. As his mother had taught him, play was a waste of time. He made excellent intellectual progress through school, completing high school at the age of fourteen, coming out ahead of his class on several occasions.

Over these years his mother trained him for a business career. She had acquired books used in a business school and the two pored intently over them. He was a model pupil in all scholastic endeavors.

However, he never was a child—neither boy, nor girl. It can be understood now why he later referred to himself as an automaton. Behind all the scholarship was a host of superstitions drilled

into him by his mother, who seldom put forward herself, but rather her false tenets, as the authority for directing his behavior. He came to believe implicitly in the magical power of the supernatural, a belief that took strong possession of him when he became mentally sick. To him everything was preordained, because mother had stressed that in all the years. His own ego was simply something that enabled him to outsmart the environment. He had so repressed his natural instincts that, until late adolescence, he was not bothered by or very acutely aware of them.

When hardly eighteen years old, he was making several thousand dollars a year in the financial field. In this he was assisted materially by the easy economic condition of the country. His mother was a success, and so was he, too, in a way, because with sums of money in his pocket he was able to capture the attention of girls. He suddenly became a "sport" among girls and, though he did not know clearly what he was doing, he strutted around with the air of a man-about-town. He knew how inexperienced he was, but he had confidence, hired from his aptitudes in scholarship.

From the age of eighteen to twenty-one, his approach to girls was almost wholly sadistic. He engaged the services of girls of ill-repute, particularly those who would participate with him in what he called a war dance preliminary to sexual excitation. Very soon he found out that he did not care for quiet love-making and, therefore, he had nothing to do with decent girls. The truth is that he was brought up on sadism, the kind his mother imposed upon him in the interest of rigid obedience. He knew, too, that he had not lived the free life of a boy and that, if anything, he was girlish.

Whenever he went to visit a girl of the type that would join him in his war dance, he carried a long, rubber dagger with him. He and the girl would then dance around as he understood Indians did, until he was exhausted. He would then fall to the floor and, according to his instructions, the girl would plunge the knife into him. He did not plunge anything into her, and therewith the girl-adventure would end.

After three years of such association with girls, the shame, which he had always experienced in the act, grew so intense that he

decided to give up such behavior. With great diffidence, he sought the companionship of a well-mannered girl and courted her for a few months, when suddenly symptoms of "nervousness" began to appear. He wanted to be aggressive to her, but realized he should not and, besides, she had indicated politely but firmly that she would not have it. The more he curbed the aggression, the more uneasy he became. He sensed that, in keeping him in abeyance, the girl, though different in age, was essentially no different from his mother. The girl did not know it, but whenever she praised him for his learning, he was terrifically irked "in my insides," the way he put it.

Gradually there began to appear obsessions at first, then compulsions as if "something inside were gnawing at me," as he himself expressed it. He could not be aggressive to the girl in any direct manner and it seemed that "the meanness was coming out of me in another form." That point of view was all too realistic to him in retrospect when he remembered the time that he suddenly found himself without any symptoms: it was when his bride-to-be was in a hospital ill with pneumonia, for which the doctor feared a very grave outcome. The obsessions returned when she was pronounced out of danger.

While he did not know it, his unconscious impulse was to get her out of the way by hurting her in some manner. Being well-versed in magical thinking, as most obsessional and compulsional individuals are, his unconscious mind assumed that her illness would result in death and he, therefore, would be responsible for it. He remembered how happy he was when his symptoms disappeared, but the happiness was ascribed wholly to his restoration to his health, while his fiancée was believed to be dying.

The obsession was to think of things three times. Whatever ideas occurred to him had to be repeated three times. Usually, they were very simple ideas, such as related to the time of the day, how he should dress, or what his fiancée was doing at the moment. Within a period of months the obsession became extremely troublesome, because he would have to bracket what he said three times and repeat it all three times again. Thus he had to repeat the original nine

enumerating the many situations in which the obsessions and compulsions occurred, giving meanwhile their developmental history as outlined in the foregoing. Later, during a review of his life from the earliest years on, he gained an insight into himself such as he had never had before. He saw clearly that he was the image of his mother and that as the years went by he never became an entity, but always remained an extension of his mother, with her incessant drive toward intellectual superiority, buttressed by a legion of superstitions. He came to realize for the first time that he had never had an emotional infancy, childhood or adolescence and that, therefore, he had not grown up as a human being. He had a woman's psychology in a man's physical frame.

Until late adolescence he was unfamiliar with his instinctual urges, save on isolated occasions, when he fearfully repressed them. From the analysis of his unconscious there came overwhelming evidence that his instincts got no further than his mother, or, rather, with the unconscious image which he had of her. This was demonstrated time and again in his *dream life* and in phantasies that came to him during psychotherapy.

It was evident to him that he had never loved anyone, nor had he ever had any affection shown to him, except the admiration of his intellectual accomplishments by his mother, grandmother and teachers. He could "love" only his intellect.

Could he have gone through life as a sexual ascetic, it is quite probable that he would not have encountered a psychoneurosis or any other type of psychiatric condition. It is not easy, however, to keep one's mental energies out of the sexual zones, to which it has been accustomed for ages. It is the only arrangement for keeping the race in perpetuity and whether we like it or not the demands of the instincts are ordinarily insensible to the distress they cause those who try to believe that they do not exist.

The energy of infantile sexuality should be diverted to various forms of play and recreation. Then it is not felt in childhood as something very troublesome, especially if it is drained off also in the form of affection for the parents and later for others.

Our patient came to sense how one-sided his life was with his

mother. He had love to live out and he consciously yearned to share it with her, but he was rebuffed on each occasion. The attention that he gained through scholarship served to take care of only a fraction of his need for affection.

His instincts could get no further than the occasional fleeting fancies of loving his mother. They alarmed more than they pleased him. Finally he succeeded in driving them into the unconscious sphere, because they were disgusting to him. *However, instincts cannot exist alone; they must have something to which to be attached.* The mental component in the unconscious to which they were linked was the image of his mother.

When in the unconscious, that is, when they are under no conscious control, the instincts are blind to any such thing as morality. They simply reach out for the most accessible object, which in the case at hand was the image of the patient's mother. Then there was the struggle, going on in the unconscious, to separate the two in order that the instincts might be directed upon a morally acceptable person.

We know how ardently the patient fought to reach maturity. We know how precipitously he rushed into affairs with girls and later into marriage in order to evade his symptoms. What did the symptoms mean?

Before we come to an answer, it must first be understood very clearly that during psychotherapy the physician was relatively uncommunicative as regards any interpretations during the period of investigation. *The solution of the meaning of a psychiatric symptom is totally dependent upon the material provided by the patient.* Some people think that the psychiatrist has the meaning of symptoms somewhat in the form of a list and that all he has to do is to consult the list and presto!—there is the answer. Nothing is further from the truth. There is no standard interpretation, for the simple reason that the same word or idea or symbol seldom has the same significance to two people. Moreover, it should be remembered that the symptom, in this case the obsession, was intimately related to a complex in the patient's unconscious, much as a pipeline extends below the surface of the ground to the water it

is pumping. Any water that is put into the pipe from above, that is, any help given by the psychiatrist, can act only as a primer, as a stimulant, but it certainly cannot take the place of the water from the well below.

When the patient discussed his symptoms, the obsessions, for purposes of trying to find out what they meant and whence they arose, he was at a complete loss in the beginning. That is the situation in which all psychoneurotic patients find themselves. To them the symptoms stand detached and alone. In the case of obsessions, however, the patient knows one more fact, namely, that there is almost always a magical formula which serves to palliate or to stop the symptoms for a moment. Our patient was acquainted with two observations: first, that he had intolerable anxiety along with the obsession; second, that the anxiety was instantly relieved with the expression "God forbid."

It was obvious to him that, in its way, the anxiety is a thousand times more painful than any physical pain could possibly be, because it threatens to destroy the mind in a horrible way. The feeling the patient has is that it will make him crazy. This much he knows before he analyzes himself. When we ask what will be the result of his craziness, at first he honestly says that he does not know, that the question has never occurred to him. On further inspection he gains the feeling that *he* will not die in his craziness, even though the violence in his mind is terrific. He realizes that the violence will be destructive, but by some miracle *he* will not be destroyed: who or what will be destroyed is the problem.

We cited from experiences with other patients that some patients have for years suffered from a fear of imminent death and yet they are exceptionally healthy from the purely physical point of view. The patient is amazed that such a gigantic force hammering constantly at his mind does not kill him, indeed, that it does not even leave a memory scar once it has stopped pounding him. In his fleeting periods of relief he can think as clearly as he ever could. This observation set our patient wondering what the anxiety was about. He soon knew that it was destructive in its aim and he was not the one to be destroyed.

After a thorough survey he concluded that the terrible force in him would not hurt his body either. All the laws of physics seemed inoperative. Here was a vast power militating against a frail object and the worst that happened was anxiety, a terrifying anxiety. He was helped by a few references to analogous conditions, such as the young man who feared that illuminating gas was escaping from the burner in his room and, though he was the only person in the room, with doors and windows closed, he was amazed to find out that the gas, if it leaked, would not affect him in the least. Another patient dreaded the awfulness of the death he will bring to others, because, as he thought, he breathed out noxious germs, yet, it never occurred to him that if he had in him such death-dealing germs in the vast quantity he believed—he is always exhaling them—he should be the first one to die. *Organic laws have no place in mental symptoms, but psychological laws certainly have.* The patient was not relieved to know that the anxiety would not kill him or make him crazy.

We made a short summary of the events up to this part of psychotherapy. He had already gone into much detail about his life. He saw how he had been sacrificed to his mother, who, he found out, was entirely selfish in bringing him up. She did not think of him, but of her own drive to get to the financial top. She saw in him the promise of furthering her own ends. He recalled that his mother told him that he was more likely to succeed than she was, because she was handicapped by her own past. She knew he was fresh material and could be molded to her designs. The fault in her plan was that she reckoned only with his intelligence. She could control what went into his mind. Being blinded to her own instinctual self, she could not see it in her son. Little did she know that a gush of water finally would come to the surface to crumble the sandhouse she so painstakingly had made.

The review went further. For the first time in his life he sensed the narrowness of his life, how he was kept from playmates in his childhood, how he carried that restriction through his school days, through his working career. Then he observed how he finally broke away from it all, broke away from his mother, how he "sexualized"

himself violently with girls, then became remorseful and married a girl of an entirely different, quiet type, but one very much like his mother.

He was beginning to see that perhaps there was some connection between his mother and his obsession. Yes, he added, there really was. Then he recalled the great alarm he used to have about his mother's health. Starting when he was about seventeen years old, he used to be troubled with the thought that some day she would die. He drove the idea away quickly, but it came back to him with increasing frequency. He grew very emotional in recalling her prolonged illness when he was about twenty years old. The doctors were never able to find an organic cause for it. He was deeply worried, not alone because she was ill, but also because he had to nurse her each evening. He recalled that, though her sickness came first in his attentions, he was not at all unmindful of the fact that it came at a time when he was just beginning to branch out in life and to enjoy experiences with others. His mother did not know where he went nights, but she frequently remarked that he was a bad boy for going out. In order to placate her, he switched his appointments with girls from evenings to late afternoons. He remembered many facts that led him to feel sure that her prolonged illness started shortly after he began to stay out nights and ended at about the time he resumed the practice of staying at home with her.

Slowly it dawned upon him that his mother did her utmost to keep him at her side. In his younger years, she held him to her by direct and forceful action. During the subsequent years, she did not have to exert great pressure upon him, for she had already conquered him. Yet, that was not exactly true, because when he began to try to grow away from her, she resorted to illness as the means by which to retain him.

Ordinarily a patient has mixed feelings when he begins to understand such facts as the foregoing. He is disappointed to know that one who professes unending love for him can plot to keep him enslaved. Our patient was at first bewildered. How could his mother have been so selfish? But, he quickly added, she was not selfish.

She sacrificed herself to his interests. No, that was not true, either. Then a momentary burst of anger came upon him, followed by sadness.

It was by no means easy for him to size up the situation correctly. During successive sessions he labored and labored over the problem, and while he did so, his underlying emotions came out in dribs and drabs. He was steadily gaining release. When finally the unconscious feelings had been essentially drained off, he was able to appreciate some of the major factors which bound his mother to him and him to her.

Neither he nor his mother was to blame. He saw that she had been unwittingly trapped in her younger years by circumstances over which she had no control. She, too, struggled to free herself. She tried to grow up. She could not. It was not merely selfishness on her part to cling to her son. She simply did not know better, that is—emotionally.

He came to realize that she, as well as he, was the victim of forces far greater than either of them. However, he was able to arrive at such an objective opinion, only after he had given vent to the deeply-lying emotions which had held him captive over all the preceding years.

To be able to arrive at such an objective point of view is not at all easy. Psychoanalytic treatment is a slow, painful process which for a long time tosses the patient hopeless and helpless upon turbulent seas of emotions. To those who have not had long experience with psychotherapy, there is the great temptation at times to take sides with the patient, at other times to feel provoked by him. *The physician should not play an emotional part in the drama being unfolded by the patient.* If and when he takes sides, losing his objectivity, it means that the patient's problems have stirred the physician's underlying complexes into action, creating a situation that is not to the best interests of the patient. Before undertaking to treat a patient with an emotional disorder, the physician himself should have undergone psychotherapy in order to rid himself of his complexes. If he does not do so, the great chances are that, without knowing it, he lives out his complexes upon the patient, a con-

dition known as *counter-transference*, which can be either of a positive, i.e., sympathetic, or of a negative, i.e., antagonistic, opposing nature.

Under conditions most favorable to the patient, *the flow of emotions is in one direction only, namely, from the patient to the physician*. The latter should maintain an attitude of objectivity. That is not always easy, to be sure, especially when it is realized that in psychotherapy the patient unwittingly gives the physician the qualities of those people in his life to whom he is emotionally bound. Thus, when the patient is releasing upon the physician antagonistic feelings that were originally connected with the patient's father, the release may be so realistic that for the time the patient acts as if the physician were his father. This process, known as *transference*, is evident also with respect to the release of other feelings, as they flow from the patient's unconscious out onto the physician. It is the function of the physician to *help the patient to understand the origin of the feelings, because successful therapy is dependent upon such insight on the patient's part*.

Another point that bears repetition has to do also with the physician's objectivity. *The physician should be careful not to draw conclusions about any topics significant to the patient's emotional growth, until the patient has given ample facts of his own experiences and impulses to insure the validity of the conclusions*. Under such circumstances the physician's conclusions are unnecessary, since the patient himself ordinarily arrives at them without the physician's assistance. The physician should not feel that his authority comes first. On the contrary, he should feel pleased when the patient alone grasps the import of a deeply rooted psychological problem. Through his experiences the physician should be able to judge the merits of the patient's conclusions.

And so our patient is irate about his mother, but he does not want to be; then he does. In this way, for days and days he straddles the issue, sometimes leaning to one side, sometimes to the other. He is prevented from seeing the truth, because he feels that to rebel against the training his mother has instilled in him is a mark of brazen disloyalty. During psychotherapy he should not stand

against her as a real person, yet he must not continue to be influenced by her in accordance with the disciplines she laid down for him in his earlier years. He comes to realize that it is *the little boy in himself* from whom he wishes to be freed. He comes to know that it is not his adult self in the main that bothers him, but it is *the dominance of the little obedient boy* in him that needs to be gotten out of the way.

For a long time many patients make the mistake of confusing the little boy's drive with the big one's. Of course, the motives of the two may be identical, but ordinarily it is not so in the psychoneuroses, which represent efforts for and against—let us say—undue mother affiliation. *Psychoneurotic patients do not consciously want unwholesome relations with the parents; that is one of the reasons why they have a psychoneurosis.* But there is another person in the patient, the youngster who got there first, the one who was really influenced, the one who has strength, whether it be good or bad. *Man's greatest rival is within himself.* It is this other person who fights to retain his position, as untenable and as futile as it may be. This distinction is always difficult for the patient to grasp, because the younger, but more powerful fellow who got there first, overwhelms the older one, so to speak.

The patient is still irate at his mother. Sooner or later he begins to feel that perhaps the destruction hidden in his anxiety represents a way of getting the mother influence out of his life. He now begins to see a sequence of events, obsessions, of which the troublesome feature is great anxiety; anxiety is dread, awful fear. First he had the fear of going crazy; *his* mind would be destroyed, so he thought. Then he ruled that out. It would not be *his* mind. However, the idea running through his obsession was the fear of destroying the mind. Could it be his mother's mind? He follows the question with a recital of more experiences, keeping the question close at hand. He eventually concludes that the greatest handicap in his life was twofold, *first, his mother's training of him, second, his abject obedience to it.* It surely seems as if he could wish that his mother's mind had been useless, crazy, futile. Then it might never have distorted his life as it did. But, it is the high-handed

grafting of her mind upon his that has to be removed before cure of that item can be effected. This likewise includes the extirpation of the unconscious sexual links between his mother, as she appears in his mind, and his own instinctual sexual manifestations.

The patient came to understand the significance of the expression "God forbid," by which the anxiety of the obsession and compulsion was relieved. He had previously noted that the anxiety seemed to be associated with some disaster or catastrophe, the nature of which he did not know and that the "God forbid" meant that he prayed to God to prevent the something terrible, whatever it was. During the discussion, he recalled that in the very early stages of his mental disorder, when the obsession was beginning to irk him, he used to telephone his mother to inquire about her health, although he was not aware of any sickness or indisposition on her part. He was frequently embarrassed, because she intimated jokingly that perhaps he wanted her to be ill. As his neurosis progressed he "forgot" that interest in her health. During psychotherapy he tied it up with the "God forbid." The sequence was as follows: the compulsion from which he suffered was his symbolic way of killing his mother; it created intolerable anxiety in him, anxiety which could be dispelled only by the magical formula, "God forbid."

The obsession was a symbolic, aggressive move to banish the source of his anxiety, namely, his mother. But there were other women to whom from time to time his compulsions were directed. They were his grandmother, wife and the ones with whom he indulged in the Indian orgy. Eventually his unconscious troubles were cleared up. In the course of treatment there were other complexes to handle, such as those connected with his father or with the masculine side of his development. These problems were more easily recognized and managed by him.

As a result of the psychoanalysis he was rid of the causes of his psychoneurosis. But, he still had more to do before his emotional age caught up with his chronological age. *Once his complexes were out of the way, he did not need very much active help from the physician, because he was then free enough emotionally to extend*

his mental energies gradually into his personal and impersonal environment.

During the analysis he saw, for the first time, that he had originally been drawn by his wife because of her maternal qualities. He saw only the mother in her and marriage was psychologically merely a continuation of his son-like attitude, this time with *his wife as the mother*. It is a very common observation that *psychiatric patients see in people what they deliberately or unintentionally want to see in them*. It is a form of *misidentification* that the patient does not recognize as such, but which is *felt, often too keenly, by the one misidentified*. "Who do you think I am, your mother (or father, or slave, as the case might be)?" is a hackneyed question, and exemplifies well the psychology of making someone what he is not. Marriages may be more or less openly consummated on the basis of psychological need, apart from anything rational. A girl, needing a father, may marry a man old enough to be her father or one not that old, provided he acts as a father to her. Or, if she had earlier shifted from her father to her brother, she may marry from the standpoint of a brother-sister relation. Our obsessional patient married a mother substitute. She knew it but too well just a few days after marriage and asked herself whether the time would ever come when her husband would see her as a wife. What she did not know was that in marrying she accepted him for what he was, a son, and therefore, she was to be the mother.

Towards the close of the psychoanalysis, however, he divested her of the role of mother through changes in his attitude towards her. No longer needing a mother, he recognized her as a wife. Fortunately she was able to move up into her proper role with him.

Sometimes it happens that when a wife (or husband) begins to realize that the life partner is changing from the part that led to their marriage, all available wiles are set in motion to keep the partner in that first role. The marriage sometimes is dissolved, particularly if the married couple, free from any formal symptoms, fail to recognize the involvement of the deeper psychology that is causing them turmoil.

Marriage is a stepping-stone to maturity, but not maturity itself.

Most people have only themselves to blame if they do not recognize this simple truth and look to marriage to perform the impossible task of magic transformation: to endow them in 24 hours with all the fully formed habits of maturity. When this childish phantasy is instantaneously wrecked by stark reality, the inevitable disillusionment leaves them utterly befuddled. Man's shortsightedness in this respect would be amazing if it were not almost general. In just what other department of living do we expect to jump overnight from inexperience to experience? Certainly not in intellectual achievement. We know that we must study for years and years to reach the right to practice a profession—that is, just to begin it. With keen appreciation of the newness of our acquisition of knowledge, we purposely plan the progress we hope to attain over the coming years. We do all this for something, our intellect, that is obedient to us from the start; we do it for something that does not kick back, because it is a more or less inert receptacle, of limited capacity, but holding what we put into it. There can be a tempest in the teapot, to be sure, but that is not due to the teapot's normal contents, but to the chemicals (emotions) added to it.

Surely it is not reasonable to expect to advance overnight from physical awkwardness in sports to equality with the professional athlete. Again we allow for years of hard, steady practice, starting as sandlot players, going next to the grade school team, then that of high school and college, after which we are farmed out to a minor league team, and thence to the major league.

Nor do we gain eminence quickly in avocations. We allow years for the achievement of a position of soundness in music, the theater, travel, and so on.

How much time and study do we give to the most valuable of all our possessions, the qualities of being a happy human being? That is, to our emotions? *If we gave as little time to the training of our intellect as we do to our emotions, very few would rise above the level of idiocy.* That is a severe indictment, yet to what extent can it be denied? It is a pathetic commentary that what we look for most earnestly, what we search for with high diligence during all the years of our life, what we have right before our eyes

all the time, we do not see, or seeing it, we do not know what it is! This is not said in the nature of complaint or disparagement, but rather as a deliberate incentive to spur us on to look into ourselves with the instruments that have been developed to date. The science of psychiatry is young but robust and it can perform a task commensurate with its age.

Mania and Melancholia

In the preceding chapters the prevailing idea was that psychoneurotic individuals divert the emotions of their unconscious complexes into two main divisions of abnormal manifestations.

(1) In the first place, the emotions may invade one or more of the organs of the body, leading the patient to believe that he has an organic disease. When a single organ or organic system takes the brunt of the mental conflict, it is commonly said that the patient has an *organ neurosis*. Thus he may have a cardiac or a gastric or a neurologic neurosis. Today the phrase *psychosomatic disorder* is also used to designate such a condition.

When the energy of a mental disturbance spreads more or less diffusely throughout the body, inducing mental and physical *fatigue*, with greatly diminished power of mental concentration and generalized weakness over the entire body, the patient is said to be suffering from *neurasthenia*. In this condition the general impression is gained that the total amount of energy available to the body and mind is much below that present in the average individual. It is probable that clear-cut cases of neurasthenia may be related to organic deficiency in ways not yet understood, much in the same manner that those patients to whom the diagnosis simple schizophrenia is applied seem to be inadequate in virtue of possible energy deficiency.

Other individuals seem to express their mental difficulties in terms of widespread physical disorders that shift from one organ to another with relative ease. From the viewpoint of their symptoms they seem to occupy a position somewhere between the hys-

terical patient whose energies are concentrated in a single organ and the neurasthenic in whom the energies are diffusely spread without prominence upon any particular part of the body. These patients are described as having *hypochondriasis* and it is noteworthy that any part of the body may be afflicted at any time. Psychiatrists are still considerably baffled by neurasthenia and hypochondriasis, not so much from the diagnostic as from the therapeutic point of view, as well as from the point of view of etiology.

(2) The second general way by which emotional troubles may be expressed is through special symptoms of the mind itself. We saw that the usual, habitual character traits of the individual might be so intensified as to lead to an abnormal type of personal and social adjustment to which psychiatrists have given the name *character neurosis*. These people are popularly known as "characters," perhaps because they are too fussy, too meticulous, too exacting—or they may show unusual intensification in point of submissive traits, the *Milquetoasts*—or they may be alarmists, the *Calamity Janes*. They are not sick in any formal sense, but they stand out as different.

Then there are those who cannot expend their tensions in wholesome environmental pursuits. Their inner mental troubles are of such a nature that they cannot be converted into sublimated or socially acceptable forms of activity. The excessive emotions derived from what are known as unconscious complexes finally find an outlet, poor as it may be, through such abnormal symptoms as anxiety, fear, obsession and compulsion. These symptoms serve the purpose of concealing the underlying causes from the patient and from others. They are the patient's protective device, because they at least defend the individual from the more severe ravages that would ensue, if the primary enemy had to be met face to face. No matter how much anxiety may be associated with a fear of insanity, it is still less than that from which the anxiety originally springs, which may be the unconscious urge, let us say, of a daughter to kill her mother. When the solution of one's mental stresses takes the form of anxiety, fear, obsession, or compulsion

as the principal way out, it is said that the individual has a *psycho-neurosis*.

The vast majority of psychoneurotic patients possess another distinguishing feature, a very highly important one, particularly from the standpoint of yielding to treatment. These patients are commonly of a sound physical and intellectual constitution, both of which—and this is the significant feature—are usually put to good, though restricted use in social adaptation. These individuals ordinarily manage to integrate themselves with their surroundings, not to so high a degree as the normal person does, yet they do not give up the struggle for being human beings among human beings, difficult though it is for them to maintain some semblance of socialization. They remain a part of the social order in which they live and not infrequently they make excellent contributions to its advancement.

There is another large group of patients to whom the diagnostic term, *manic-depressive psychosis*, is applied. They are so-called because generally they have two separate and distinct phases in their illness. In one phase, designated as *manic*, the patient is forever on the go, physically, mentally and emotionally, while in the other he is underactive in those three spheres. He is then said to be in the *depressive* stage.

While there are exceptions to the rule, ordinarily manic-depressive psychosis occurs as episodes; the mental disorder is not chronic and continuous, but in spurts. Some of these patients have but a single attack in a lifetime, while in others the attacks may appear with some regularity over a period of many years.

The members of this group of mental disorders appear to have a special personality fabric, one that has close likeness to that of normality, but which is characterized by thinness, so to speak. Theirs is a personality structure capable of sustaining them well in childhood, less well in adolescence and still less successfully in later years. Perhaps they may best be understood as being people who, without treatment, have to get along in life with mental and emotional equipment adequate for childhood, but not for the later periods of growth.

It was previously indicated that the normal, healthy infant is destined to grow slowly in personality. From the very start he has potentialities for personality development, but the environment has as yet neither contacted these potentialities, nor merged with them to produce an instinctual-environmental combination. The first portion of the infant's surroundings is the parents, particularly the mother, who gradually refines the crude ores of instincts into finished products. In the beginning she is part of the infant in the sense that she personally bathes, feeds, dresses, and moves him about the environment. She is the motor power for his body for many months. As the child grows older, mother steadily teaches him to use his own body energy.

Then she has the responsibility of providing direction for the energies of his developing mind. Again, in the beginning, the instincts of the mind are unrefined and mother has to take each one separately and make it suitable for environmental expression and adjustment. This is the period in which, among other things, a multitude of prohibitions appear. It is "no" to this and "no" to that, supplemented by an equal number of "yes"s. "No, you cannot hit your little friend, you must be nice to him." "No, you cannot tell that story, people will not like it. You should tell them nice things." "No, you cannot eat with your fingers, you must take the spoon," and so on, and so forth—a long series of "no"s and "yes"s extending not merely up to but often far beyond the advent of manhood.

In this period of development the child learns how to substitute new behavior for the old. Mother teaches him not to break his toys, but to keep them whole; she shows him the superiority of cleanliness over dirtiness; of orderliness over disorderliness; of kindness over hurtfulness; of good manners over bad ones. And so it goes with all the habits that should be abandoned in favor of newer ones consonant with his age.

In this period of growth the personality organization of the child is distinctive in that the child is expected to reverse himself, so to speak. Cleanliness, orderliness, punctuality, for example, take the place of their opposites in the daily life of the child. The suc-

cess of this process depends in part upon the parents, in part upon the child. While it is going on, it is said that the child's personality is in the phase of *reaction- or reversal-formation*.

In the normal child the discarded habits of infancy have a special destiny. The original oral, anal, and genital habits usually are *repressed* into the unconscious, while their energies are given over to habits of *sublimation*. This can be simply illustrated in the example of the child who is taught to take pride in showing off his clothes instead of his body.

The individual who may later suffer from a manic-depressive type of mental disorder, may repress the old, instinctual habits, but *he does not divest the habits of their instinctual energy*, at least to the extent of there being a guarantee that they will not subsequently cause him trouble. Containing, as they do, an overstock of instinctual energy, the old habits are ever-ready to stir up trouble.

Thus in consciousness there is a set of regulations which have their opposites in the unconscious, a bipolarity, so to say, between which the emotions shuttle. When the child is faced with a situation concerning which he has some doubt as to how to act and feel towards it, he wavers as to whether to take this or that course: shall he reach out and take the toy for which he yearns or shall he make up his mind that, since it is not his, he should not take it? The emotions first say "yes" then "no." This is one of the simplest examples of the form of personality organization that takes the name *reaction-formation or reversal-formation* and is also an example of what is called *ambivalence*, the simultaneous presence of impulses that oppose each other.

Some children retain this level of personality organization as their dominant form of adjustment to nearly all their problems of living. They may be abetted in it by one or both parents who cannot make up their own minds as to how to advise the child. Mother has taught the child not to lay hands on the property of another, but she is so affected by the child's longing that she hesitates to be firm. Sensing this hesitation, the child begins to show that it feels awfully hurt and mother is further softened up. She

might well have solved the question in the first instance by a reasonable explanation that the object belonged to someone else and, if she really meant to do so, that she would soon get him one of his own. Or, she could have shown him in a kindly way that he was not yet big enough to use it and she would get him one as soon as he was old enough. But in this case she was not certain, so he put on his little tantrum, she became less certain, and finally he got what he wanted. He snatched success when the interdiction gave way to a grant. Mother is hurt by it, but the boy is glad and assuages her hurt with his delight at her generosity. Then father, returning from work, reviews the whole transaction and father's feelings become a part of the experience.

When this way of meeting prohibitions is more or less habitual the youngster realizes how easy it is to gain his ends. He pits mother against father in the most subtle ways and while they strive to rationalize their opposing points of view, more frequently than not, the chances are the final decision will be in the boy's favor, perhaps, as a clear-cut victory or perhaps with a proviso that he will have to be more attentive to his school work as his purchasing price—a price which he meets for a day or two. Maybe he does not even pay the interest on the debt.

One of the handicaps of the indecisive parents who are always compromising in favor of the child is the bad pattern that is set up in the child's mind. He (or she) may go through life debating inwardly whether to do this or that, always with the knowledge in the background that the answer will be in his (or her) favor, even if it should be necessary to pout or whine or beg, as is usual in dealing with the parents. There is the equally baneful possibility that, never having had the full responsibility for making his own decisions, his "*thinking*" during adult years is determined reflexly or automatically, that is, by the pattern settled in him by the parents. To all intents and purposes he looks and acts like an entity, but he knows better than anyone else that his mind is really not his, but his parents'.

It is easy to understand why he has feelings of inferiority, which he tries to cover up with intellectual achievements, or with acts

of physical prowess. Since intelligence in itself is usually an ineffectual prop for the emotions, there is always the hazard that the ways of the parents may not be a successful guide in the later problems that he has to confront.

Among psychiatrists it is a well-known observation that when such a person finally takes a heroic stand to assert his own individuality, he frequently has to exert himself so excessively that he destroys the very aim of his efforts. The degree of overcompensation that he has to employ in order to give strength to his own ego is beyond his control and he succumbs to the mental state known as *mania*, the nucleus of which is an unlimited expansion of his ego, as well as of the instinctual components of the unconscious. In this gleeful and omnipotent state, the patient brooks no interference, because for the first time in his life (assuming it is his first attack) he is totally free to think, act, and feel without restraint.

While the foregoing seems to be the usual sequence of events giving rise to such a weak formation of character, the responsibility should not be placed wholly upon the parents. Experience shows that *on the part of the child's mind* there are all grades of susceptibility to parental influences and they, too, demand as much consideration as do the disciplines of the parents. Instances are at hand in which in spite of sensible up-bringing, the child cannot emancipate himself from the habit of being the image of the parent. In extreme cases, even with the best of skills, it does not seem possible to build up enough individual initiative, enough "strength of character" in the child to insure the minimum of wholesome adjustment.

There is no fixed formula for rearing children. The equation is different in each family unit and it is the recognition of this variability that must precede any remedial measures. Errors in the management of difficult home situations are all too common because we do not take the time to scrutinize closely what we are about to judge with finality. The prescription should read: *twenty parts of examination to each part of conclusions, the remedy to be taken in small doses daily for a year.* That is a reasonable prescription, rela-

tively easy for anyone to take, and when taken properly is a more than average guarantee of good health. It is certainly worth the effort, as is anything that holds out hope, not alone for the prevention of a disabling mental disorder, but also for the amelioration of the difficulties of everyday life.

The people of whom we are speaking have often been "on the ragged edge" for years before the complete breakdown. They are always in an embryonic psychosis. They know it; their associates know it. Even if they have never stepped off the brink, it would pay them well to get away from it.

When, perhaps in adolescence, perhaps later, this unstable person cannot integrate himself emotionally, he may strive, almost frantically, to release his unconscious, instinctual energy through constant application to work, day and night, all his waking hours. By concentrating on work, work, work, he succeeds for a greater or lesser period of time in holding his inner personal needs in abeyance. But, he is only shutting his eyes to an oncoming danger. He exercises himself beyond all reason in absorbing the environment into himself, by always being in contact with it. If he is studiously inclined, as he very often is, he keeps taking in and taking in, showing an insatiable appetite for acquisition. There is a compulsive need in him to be a part of his surroundings and in his frantic effort to be inseparable from it he loses his own identity. When you sit down with him for two or three hours, he is tense to receive impersonal information but more so to give, and it is noteworthy that he seldom talks about himself, but about the things he has learned from the environment. You are impressed with the fact that, having listened to him for several hours, you have not learned anything about *him*, about *his inner self*, but have acquired impersonal data that you could have gathered from other sources. You realize that the qualities of human nature, of which you get a little inkling from him, are buried beneath a welter of impersonal facts. Where is the man? You do not find him.

The environment as it comes back out of him seems to him to be an impenetrable barrier. It is his defense against knowing his inner self, as secure in its purpose as are the barriers set up by other

people, who without knowing it use anxiety, or fear, or obsession, or a physical complaint, as a means with which to conceal themselves. His strength of character is like that of a papier-mâché fortress. From a distance it looks formidable; to the closer view its weaknesses are evident.

This type of person is not difficult to identify. It is true that he is made up of the realities, the externalities of life, that he has no "peculiar" character traits, that he likes people and things, that he is never idle. But, the great fault in this *extraverted* individual is the *excess of objectivity*, so to speak, with which he strangles himself.

The time to spot his trouble is before he ever succumbs to the crushing of his human self by the weight of the environment. His parents, schoolteachers, and associates know that he is "riding for a fall" and the first two are in a position to do something about it, for they can at least advise him to include some everyday forms of human activity; to be a boy among boys; to stop running away from himself all the time. When he does take up a hobby he should be careful that it does not mean to him another of his formal pursuits. If he enters the field of sports or other forms of diversion with the enthusiasm that he lavishes on his school subjects, they soon become matters of intense study and merely serve to stop up some additional gaps through which his human qualities might trickle.

His affiliations with girls are of the same general order, for the only part of himself that he has to offer them is the synthetic and artificial structure of extra-personal origin and, while it leans to propriety, it cannot cope with the June moonlight. It is a business asset wrongly placed. Both he and each girl know it, yet nothing satisfying is done about it. The girl appreciates his intense desire to get ahead in the world, but she craves for and would appreciate some affection for the sake of affection.

To him courtship is a business-proposition or an object of study and the girl is subjected to minute analysis from that point of view. He evaluates her character traits: will she retard him in his progress towards leadership in his field? No, because on several occasions

she was understanding and sympathetic and tolerant when he had to give up their projected holiday trip in favor of work—work which he had half-knowingly devised, because on their last outing she had pressed him (so it seemed to him) a little too closely for an emotional exchange.

You know this person as well as any psychiatrist knows him, but what you may not know is that *the psychiatrist meets many of these people in his office when they are on the verge of or actually in a "nervous breakdown."*

With all the drive and leadership which give him the appearance of strength and confidence, this person's close associates in non-business matters recognize that he is backward in contacts of a more or less personal nature. Quite apart from his business accomplishments, he is a boy. No one knows that more clearly than his fiancée or wife, with whom he can be irritable and petulant when he wishes to avoid, let us say, a social occasion simply for the sake of sociability. The bigwig may be easily reduced in stature when forced into an emotional corner.

Too frequently we regard extraversion as the pattern of living without realizing that excessive extraversion is just as dangerous as too much introversion. The important question is: how does the individual get along with his extraversion? *If extraversion does not bother him or others and has substantial compensatory accomplishments, it is an asset.*

MANIC PHASE

The individual whose conscious mind is the more or less exclusive product of the environment, in the sense already indicated, is likely to succumb to a mental disorder. Down deep in his unconscious are the instincts ever clamoring for recognition, but the best they can expect from this individual is an occasional nod in their direction. They gain vicarious outlet through impersonal endeavors, which are seldom gratifying to the inner man. The pent-up emotions, however, keep pressing and pressing; they are as relentless in their efforts to reach reality as the individual is to prevent them from achieving it. It is a hazardous situation. That is why

it is a little hard at first to understand why a man of such "strength" crumples up before an event that he might be expected to handle with relative ease.

The cause for his mental breakdown is usually associated with his emotional life. Physically and intellectually he *stands up remarkably well under a top-heavy schedule of activities, but he cannot adequately adjust himself to emotional demands*. Hence the usual reasons for a mental breakdown—erroneously attributed to overwork—come under such categories as engaging in a love affair or the loss of some person (wife, mother, fiancée) upon whom he leaned. In any case the deep-rooted emotions are stirred up and are facilitated in their movement outwardly by the weakening of the defensive barrier that had previously held them in abeyance so successfully.

Suddenly he is overwhelmed by the flood of emotions, over which he now has no control. Serious matters of business give way to a personal joviality that had never been seen in him before. The office employees say that he is at last becoming human. He goes from desk to desk with inquiries about the feelings of others. Previously his trip to the desk of another was prompted by wanting a sober discussion of a business nature. He chats gaily about everything, tells the girls individually how attractive they are in their new dresses, then to their great surprise he has them stand up, while he surveys them with the eye of a stylist. Now, a little lace here, he says as he touches the neck of her blouse, would set her off splendidly. No, it would not go with her hair as it is, so the style of the hair should be changed. He demonstrates how it should appear. Others in the office cannot restrain their laughter and he calls them over to support his proposed changes.

Business is engulfed by familiarities. He has already made dinner engagements at a night club with four girls for tonight. It is of little consequence to him now that it is closing time and they undoubtedly have other things to do. The husband of one of the women is waiting for her, because they are going to some quiet place to celebrate a wedding anniversary. The patient hears just enough of her explanation to express great delight that they can be

his guests at a real celebration. Everybody is gay; nobody knows what is going to happen; the women steal away, and he ends up at a cocktail bar with a few of the male office help. He had already called his fiancée to join him. He simply told her where to meet him. She was trying to make it clear to him that they already had an appointment to visit his mother who was ill, but he did not hear her.

The next morning he is up at six o'clock with more things to do than he can possibly carry out, and, he believes, they are all pressing for immediate action. He calls the trade by telephone, getting many of his customers out of bed to answer the phone. He is full of exuberance, explaining the plans he has for a tremendous increase in the volume of business. He takes everyone into his confidence as he goes rapidly from topic to topic, from place to place. The members of the family stand by as he swiftly outlines the large number of things he has to do. He must arrange for a loan from the bank, get the architect and builder together so that they can start on the plans for a new factory building. He visits the trade for new orders, has three separate luncheon engagements for the same noon. Everything is started, nothing completed, save in his own mind. The things that should be taken care of in the office are neglected. During the meal hour, he hurries to the telephone, talks at random to his secretary, interspersing personal and familiar comments, hangs up the receiver without giving her any instructions and is back at the lunch-table for dessert. He races back to the telephone to order goods in quantities out of all proportion to the facilities of his factory.

He is in the *manic phase* of manic-depressive psychosis. Within a few days he is in a psychiatric hospital, having left behind a great variety of unfinished business. His symptoms are built around one central theme, ceaseless grandiosity; he is the center of all thought, of all activity. By this time he has lost all sense of logic and coherence. He talks continuously and fast, and shifts with amazing ease from one topic to another. While being physically examined he offers gay comments with each new move of the doctor, grabs instruments from the doctor's hands and attempts to use them on

the doctor, meanwhile praising the nurse for her good looks, but she should not have to wear cotton stockings, and—there goes the telephone bell, he should call the office, it's the bell for the tenth and last round, he jumps off the examining table to shadowbox; then he demonstrates his prowess as a sprinter, showing the advantages of the best starting form, or sprioting form, racing forms, the other day he placed a bet on a horse, it should have been placed on a girl, but he does not have to bet on girls, he's a sure winner with them all. . . .

He laughs heartily at his own comments and fails to appreciate the turmoil he is creating. He is showing what is called "a flight into reality," meaning that he is showing in principle what he always possessed, the need to be environmental. But, there is this one big difference now. Before his illness he gave to the environment only what it previously gave to him; now he is flooding the environment with his instincts.

His physical activity, too, is of the same general order that it was before he ever got sick, though it is now too rapid, too changeable. The striking difference rests, however, in the fact that his ego is free; no longer is he an image of the environment; he is he and he lets it be known. The personal pronoun I stands out pre-eminently and has the quality of childishness in its demands for recognition from everybody around him. There is no conscious control of his egocentricity.

Whereas he was previously neat, clean, polite and modest, he takes no interest in his personal appearance and is unmindful of social amenities. He laughingly slaps the back of strangers as he rambles on in speech, discussing irrelevant topics with an air of authority. He approaches women with the utmost familiarity. His adult sense of responsibility has given way to the unrestrained freedom of childhood.

The symptoms of many manic patients remain approximately as just described. Some, however, regress to a lower level of narcissism in which unbounded omnipotence reigns. In this stage they are as a rule openly exhibitionistic and indulge in all varieties of sexual perversions, homosexual, heterosexual, narcissistic. They are

then said to be *polymorphous perverse*, because they give vent to the oral, anal, and genital instincts without restraint.

Through the illness there is usually no impairment of intellectual functions, such as memory and orientation. Moreover, the patient is almost always aware of the fact that his mind is working quite differently than it did before he became ill. It is said that he possesses *insight*.

Owing to incessant overactivity, technically called *psychomotor overactivity*, there appear the usual physical signs accompanying unceasing activity. The patient's vitality may become so diminished as to lead to death by exhaustion. In this weakened state he is easily susceptible to infectious diseases.

The course of the mental disorder varies greatly from individual to individual. It is in part at least dependent upon the frailty of the personality prior to the onset of the illness. *Those who were always near the borderline are apt to have a prolonged manic period of about six months.* That is the average for a large number of them. Ordinarily, too, these weak ones have a series of attacks, some few having them all their life, beginning in early adolescence. Occasionally a patient remains in a manic state for years on end, a condition to which the name *constitutional mania* is given in psychiatric literature.

The course and intensity of the symptoms range between mildness and severity and depend, as far as we know, upon the relative strength of the personality previous to the mental breakdown. Some individuals have short, and perhaps mild, manic attacks lasting from a few days to a few weeks, during which time they may maintain their usual daily activities or they may have to give them up for some part of the period of illness. Because an individual has had one attack, it does not follow that he will have others. When a manic-depressive attack first appears around the thirty-fifth year of life, the chances are even that he may not have a second attack of any major proportion. *The outlook is not nearly so favorable when the first attack occurs early in adolescence.*

Preventive treatment, *the most suitable to the individual*, and hence the most successful, is by far the procedure of choice. *Learn*

to identify this individual before his illness starts. He is the fellow (or she is the girl) who is always active, busy, on the go; he drives himself mercilessly into work throughout his waking hours. He takes little or no time for relaxation, for easy sociability. He is the person who is said to have a *Sunday* or *holiday neurosis*: when he finds himself without anything to do he gets restless and must do something. He is the tired business man who does not want to take a vacation and, when he does, is fidgety, uneasy, nervously impatient; even on his vacation he has to arrange and follow a daily schedule.

The most substantial form of treatment is psychoanalysis, not necessarily of a prolonged and intensive nature, yet sufficient to set free the underlying emotions so that they can be put to use in a variety of environmental activities. This individual needs to be at ease when the situation calls for relaxation; he needs to play for the fun of playing, to work for the pleasure of working. In some few instances a general schedule of varying activities may help him considerably, but it does not accomplish much in severer personality disorders for the simple reason that it does not cure the cause; it only covers it up and that is the very handicap under which he has been living all the time. If the individual honestly wants to correct his habits, if he sincerely desires to be a husband, a father, a friend, a worker, he will be willing to spend the time necessary to know himself.

After all, psychoanalysis is the most comprehensive technique in use by physicians today for "knowing thyself." One of its most valuable assets is that *the individual comes to understand himself through the facts of his own personal experiences. He sees himself as he is constructed and not as someone makes him out to be by theoretical considerations.* The physician's authority, backed by years of experiences, as invaluable as that may be in other respects, can never supersede knowledge of the actual happenings that have gone into the personality of this or that individual. All the science in the world about deeply seated infections is of no practical value, until it has been applied to the removal of the infection. A man, prostrate because of a whopper carbuncle, is not interested in the

theory of the disease, nor does he want the carbuncle covered up for esthetic reasons. He wants the physician to clean it out, to get him rid of it entirely. It will be a notable day when he takes the same position with respect to mental carbuncles.

The potentially manic individual may never suffer from a morbid manic attack. He may not even feel uneasy, as he drives himself along, year in and year out. *But, he had better be very careful when he approaches the short steep bump to the gate of the so-called change of life.* When he tries to make that in high gear, he may succeed by some freak of mechanical nature, though the chances are that he will be seriously injured when the car turns over several times. He would be wise to know that there is such a sudden steep incline and to make adequate and timely provision for dealing with it.

In the more severe manifestations of the manic attack, treatment is almost exclusively treatment of the *symptoms* and *not of the cause*. First of all, the physical overactivity must be reduced to the stage of rest. *Medicinal sedatives should be used very sparingly.* The most comforting relief to the patient, one that does not leave him with a terrible "hang-over," one that does not disrupt the normal physiology of the body, is afforded through warm baths in which the patient lies for a sufficiently long period to induce natural relaxation of the body. Psychiatric hospitals make provision for prolonged baths by suspending the patients in a hammock in a tub. While in the tub he may be fed frequently with a nourishing liquid diet. He may be removed from the tub when necessary to take care of calls of nature or to treat the skin against the influences of prolonged immersion. In very severe cases the mind may be put to rest by medicinal sedatives in the smallest doses necessary to give the desired result.

Judicious psychiatric nursing is an excellent additional sedative for manic patients, sometimes being the best. A well-adjusted, well-trained psychiatric nurse often means a remarkable difference to a manic patient. She knows how to tone down his overactivity; she knows how to calm him. She knows, too, that she can often divert his attention to constructive activity, which might take the form of

reading, or drawing, or performing some simple handwork. Many manic patients are like overactive children, who get into mischief when left alone, but gain a wholesome outlet under proper guidance.

In psychiatric hospitals there is very close cooperation between the nursing staff and the occupational therapy staff. While each department has its own tools and techniques, both often work simultaneously over the patient. This is especially true when the patient is sufficiently cooperative to work with others. Through the joint efforts of all he is gradually led back to socializing facilities, such as conversation, games, dancing, athletics and such industrial activities as he may like—the arts and crafts, carpentering, painting, etc.

When the manic attack is nearing its end, psychotherapy of the more formal type is introduced, superficially in the beginning, more intensive as the patient returns to his former self. The application of deep psychotherapy should be reserved for the time when the patient has been freed from morbid symptoms. But the best time to start psychotherapy, even though it may be only of the suggestive or reassurance type, is when the patient is first seen by the physician, who very slowly develops the groundwork for later mental treatment. If that is not done, the patient, upon recovery, is not as well prepared to go on with treatment, for he does not know, or does not feel, that there is any need for it, when in truth the occasion is most auspicious for the psychotherapy that aims to free him from the underlying causes.

Upon leaving the hospital the patient can be rather well guided into appropriate channels of environmental activity through the social service department of the hospital. Nursing, occupational therapy, and social service form a continuum that aims to externalize the patient's interests in wholesome activities. They are particularly helpful to those individuals whose integration had been meager before the onset of their illness.

The various forms of so-called *shock treatment* are still in the phase of research. Metrazol is obsolescent, if not obsolete. Insulin has not justified the hopes expressed by early workers. Considerable research is still being conducted with insulin as an agent of "shock"

or "coma," and the results are being studied carefully. The production of "shock" by electrical means, called electroshock therapy, is also in the research stage. These have been and continue to be worthy research projects carried on with much enthusiasm, but to date the results are of far less curative than experimental nature. This appraisal of the practical achievements seems true for all types of mental disorders with the possible exception of the disorder known as *involutional melancholia*, of which we shall speak later.

The manic reaction is one-half of manic-depressive psychosis. The other half, namely, *depression or melancholia*, may not appear at all, may be very mild and transitory, may equal the manic stage in duration and intensity, or it may be the malady's principal or only manifestation. When a patient has a series of manic attacks, it is said that he has (a) *recurrent mania*; a succession of depressive attacks is known as (b) *recurrent depression*; when either of these two states follows the other, the two together as a total are called (c) *alternating or circular manic-depressive psychosis*.

The term *cycloid*, resembling a cycle or circle, is used to designate the type of personality from which the manic-depressive psychosis ordinarily grows. Some authorities employ the word *cyclothymia* to denote mild manic-depressive states, of the kind that cannot be distinguished clearly from normal mood swings.

DEPRESSIVE PHASE

When we now turn our attention to the personality traits that forebode the depressive phase of manic-depressive psychosis, we first note that there are many grades of emotional intensity which characterize this group. An individual may ride "high, wide and handsome" for a long time and then go into "the dumps." He loses the initiative that he ordinarily puts into his activities, drags himself to work, is pessimistic and monosyllabic. Usually he has a reason for the slump, a reason that he commonly keeps secret. The boss gave him a severe calling-down for being inefficient and indicated that he might drop him from the payroll. This individual is especially sensitive to rebuffs and is always trying to win commendation.

He is easily hurt, but is still more easily hurt when the girl friend or wife intimates that she wishes he would make more rapid progress. She does not openly say that she is disappointed in him, but her envy of Jones' new car and the fact that the Joneses are renting a cottage at the beach for the summer serves to emphasize his feelings of inferiority and to make him still less capable of accomplishment.

He tries to conceal the source of the hurt from himself as well as from others. He ordinarily does not remind his wife that she has made him feel downhearted. On the contrary, in the spirit of appeasement he speaks kindly to her and acts as if he could not do enough to please her. She returns the nice words, but she cannot hide the wish he had more drive to him. Nor can she keep a modicum of impatience, perhaps, intolerance, from creeping into her conversation.

In tones of generosity and helpfulness she reminds him that he has been working too continuously. It strikes him hard, when she recalls that for the past two months they have not had their usual evening together, because he had had to work in the office. She does not and yet she does detect his being irked by this reminder. She hastens to apologize for raising the question; he assures her that she is right, but he had not intended to be indifferent to her.

Whether this type of individual is subject to *spells* of depression or is *habitually* slow and reserved, the personality traits are about the same. From early boyhood he is a *dependent* sort of fellow, genial, good-natured, honest, but is a *follower*, not a leader, save when he may be on the upswing. In spite of his reserve, he is inclined towards extraversion, always wanting to identify himself with others, yet never feeling that he is the equal of them.

He is *slow and deliberate*, takes a long time to form an opinion and to act on it, because he is fearful of making a mistake. He *thinks* over problems for *an unduly long period*, also because ideas come slowly to him. He shows what is called *initial and consistent retardation*, meaning that he is slow to start, and, having started, is slow to continue.

The same general feeling of inferiority usually manifests itself

also in the physical sphere. There is a strong *tendency towards hypochondriacal complaints*. Little ailments receive considerable attention from him. He may be a food faddist, who knows to his own satisfaction at least what dietary regimen he should follow. He is inclined to pay undue attention to infections. For instance, a little irritation of the throat calls forth a long array of medicines. Because he feels scared, his pulse rate has risen, but he attributes the rise to alleged *infection*. If he has to remain in the office, he walks slowly to conserve energy, because he does not want to overload the heart. The general idea under which he lives at the time has to do with presumed inferiority of the organs of the body. Over the years he has grown so accustomed to *thinking of his organs as inferior* that when he becomes morbidly depressed it is but a short step from feelings of inferiority to feelings of inactivity.

Underneath it all he is just as childishly dependent in his "down" moods as in the "up" ones. Psychiatrists describe his personality as *anaclitic* (from the Greek, meaning to lean against another, to lean back upon). It is the small and weakened conscious ego that stands out prominently in him. He leans back upon the parental code of discipline and training. His need for being directed is evident when he is in the "down" phase of his personality.

The commonest cause for his mental breakdown is the actual or threatened loss of the one upon whom he is most dependent. Hence, the death of a parent or of one who takes the parent's place, such as a fiancée or wife, is the usual immediate cause for a depression. The latter is ushered in by *grief* for the lost one, which has all the appearances of naturalness in the beginning, but, with time, the individual begins to grieve *for himself*. He is saddened, because *he* has lost someone dear to him. He is the sufferer, not the one who was taken from him. What can *he* do, now that *he* is alone? He is left to pine away. We sympathize with him. It is not polite to see how deeply *his narcissism has been injured*, yet his thinking converges in ever-increasing measure upon himself, and the lost one becomes a shadowy figure.

Let us see whether this apparently misanthropic point of view has any validity. The patient begins to lose weight, appetite fails,

the whole alimentary tract suffers. General strength is considerably diminished. The conscious mind loses its capacities to function well; concentration is impaired; memory is uncertain. Daily thinking habits, such as those habitually gone through in his work, are not lost, but they are de-energized. The patient says he cannot gain or maintain interests.

Mental energy, however, is not diminished. What has happened to it is that it has been withdrawn from outside activities and concentrated within the patient himself. He pities himself, for he has been left alone. A patient *expressed it very vividly when through tears he asked almost indignantly—what right had anyone to leave him alone.* To him his wife's death was "a mean trick" played upon him. Later he became exceedingly resentful, when he said that she was happy wherever she was, while he was left to suffer. We see the same idea expressed in principle in almost all morbid depressions.

The two emotional streams—the tender and the tough; the erotic and the sadistic—being no longer directed upon outward things are free to play upon the mind of the patient. We can see how the tender, sympathetic emotion goes to the individual's own ego, appearing in the form of greatly exaggerated self-pity. In his grief he turns to his parents or, if they are not living, to the images that he has of them. His tenderness goes to himself and them; theirs is directed upon him.

To understand what is happening to his emotions, we must first realize that normally, except during the early months of infancy, the two instinctual components, the tender and the aggressive, work hand in glove with each other. It takes initiative (that is, sublimated aggression) to succeed in some highly desired ("loved") endeavor. A man likes his career, but to get most out of it, he must work hard at it. Both the tender component and the tough pool their energies, or, as psychiatrists say, the energies are fused. *This is fusion of the instinctual components.*

Most people understand, too, that at times a person may show only hate, untempered by "reasoning," which, after all, is the application of the peaceful attitude. Unbridled hate or fury can stand alone, that is, defused, apart from its normal partner, love.

The same may happen to the love element. When the two are separated, we speak of *defusion of the instincts*.

Such defusion is not restricted to states of manic-depressive psychosis, though it is always seen in them. Since the energy of the instincts cannot be studied as isolated units, but can be observed in conjunction with mental and physical activities, it is necessary to see what happens to the two instinctual components as each goes its own separate way.

To be able to understand what happens to the emotions in states of deep depression, we should first see what happens to them in conditions of normal grief. The love formerly placed upon the loved one is, upon her departure, *withdrawn from her as a living being* and goes to the *memories* he has of her. This process is called *introjection*. He loves the image of her and all that it means to him. The aggressive emotion, having been released for wholesome initiative, continues to be expended upon his daily work. Gradually the *normal person* is able to re-establish his love in turn upon someone in the environment.

The morbidly depressed person, on the other hand, is incapable of developing outside interests. He had never been one to share his inner life with anyone except under very special circumstances, namely, that he take a subordinate role. It took him an exceptionally long time to share his feelings with his wife; it was a painful process for him to bare as meagerly as he did his inner life to her, because he was always a suppressed person. Now that she has gone from his life, he is lost; his emotions are aimless, objectless, but they cannot remain that way. Since they cannot go to the environment, they stay within him. The love attaches itself to *him*, partly to his own ego, partly to the image (within him) of his parents, especially to that of the mother, since he lost a woman who took her place. All of us know how dependent a depressed person is and we accept the fact that he finds solace in those he knows best. Mother had always been his comfort and he turns to her now in his troubles. His attachment to her or to what he deeply thinks of her, is too great and the love he gives her begins to make him nervous. He berates himself for his seeming unmanliness, saying to himself that he

should be strong enough to overcome his grief. He argues to himself that only a youngster feels and acts as he does. He is right, for he is now but a boy.

The course of the love component thus far has been this: in its normal expression, joined with initiative, it flowed out upon his wife. When she went out of his life, the two components turned inwardly upon the memories, the image of her. This inward turning of the emotions upon the mental image is called *introjection*. Up to this point his reaction is *grief*. Prolonged or excessively deep grief leads to a feeling of futility and frustration, which in turn gives rise to *anger*. We are familiar with such an emotional process occurring almost daily. A man, deeply in love with a girl, showers her with affection. In the beginning she may take very kindly to his expressions of love. Later she leaves him; he tries repeatedly to win her back; she does not return to him. He may then hate her to the point of wishing her dead or of actually killing her. He has nothing but fury for her, and complacency for himself. We say that the instincts have defused, the hate going in one direction, the love in another.

The foregoing is little different, if any, in those who fall sick due to frustration. The difference is *the way the saddened person reacts*. He does not act directly upon the one who left him, but upon the mental picture which he has of her. The emotional result to him is the same. Love in the form of self-pity goes to him, while the hate is spent on the one who frustrated him.

The depressed, dependent patient, having given up his work, diversions and associations with others, is left alone with his instincts and they are separated from each other. But, he has also regressed, for he is now motiveless from the standpoint of the environment. He is a little boy again, alone, dejected, and helpless in the great wide world.

But, his instincts are indestructible. However, they cannot exist alone; hence they seek the nearest available medium which can hold them. That medium is the image of his parents, existing in his unconscious; it is his *super-ego*, that guardian of the instincts developed in his infantile years. It is to the *super-ego* that his

instincts go now that they have been suddenly withdrawn from the environment as well as from the conscious part of the patient's mind.

They are withdrawn from his conscious mind. No one knows that more clearly than the patient, who says that he cannot think, cannot concentrate. He says his mind is dead; it is a blank. It is dead, however, only in that he can no longer use or control it. But, his mind is by no means inactive. On the contrary, it is full of horrible ideas and impulses that are as foreign and as disabling to him as are the obsessions of the psychoneurotic patients. Indeed, the depressed patient is now at the mercy of the terrible impulses from within himself, for his instincts have not only re-established their connections with the parental images within him, but he is helpless to do anything about it.

His deep melancholia is but a slight variation of the Oedipus complex, a variation only in the manner of expression. With his instincts now in full play with his parents, or, rather, with the mental images of them, the patient feels ridden with guilt and the impulse to kill himself, as Oedipus did.

It is really pathetic to witness the futile struggle going on. The patient condemns himself beyond measure, carrying the condemnation back throughout his past. He maintains that he is no good, never was, never will be.

The outward symptoms, in addition to those mentioned, testify to the patient's misery and the heroic efforts he makes to cast off the horror. To do so, he may go into what is called the *stupor stage* of manic-depressive psychosis, in which he is more or less completely inactive. In it he has no thoughts, no feelings and there is no movement. It is the extreme response to a frightful situation. The patient *is scared to death*.

In this death-like state he is as helpless as a newborn babe. He has to be fed, bathed, dressed. The turmoil of his mind did to him what it usually does to mentally sick people—it first took him away from the social order, then caused him to regress and regress until he reached the level of *helpless infancy*. In his regression he passed from his wife and children to his own parents or his images of them.

En route he lived through the Oedipus complex in all its negative manifestations and finally regressed beyond that to the phase of helpless infancy.

The foregoing account constitutes the nuclear elements of the depressive phase of manic-depressive psychosis. Just as there are all degrees of intensity of the manic stage, so, too, there are all degrees of intensity of the depressive phase.

It appears that regression to the infantile level occurs in both manic and the depressive stages of manic-depressive psychosis. The great difference is that in the manic phase the patient does not struggle against the regression; indeed he seems to enjoy it thoroughly, while the depression represents a violent and hopeless struggle against it.

By far the greater number of patients recover from their symptoms, returning to their condition as it was before the onset of their illness, this with or without any specific treatment measures. Whether or not it is correct to regard it as a self-limiting disorder, it at least has that appearance.

Manic-depressive psychosis should never be thought of as inevitable, because very frequently it is preventable.

When the symptoms are well-developed, it is not possible to employ curative psychotherapy. Indeed, it is frequently dangerous to do any deep psychotherapy during an attack, lest the patient, becoming too aware of the underlying causes, commit suicide. Supportive psychotherapy in the nature of suggestion and assurance helps to tide the patient over his illness.

It is especially desirable also to institute such measures as may serve to restore and maintain body functions. The gastro-intestinal tract merits special consideration. The patient should be given easily digestible food. Intestinal evacuation should be regulated. In the form of stimulating baths, hydrotherapy is often valuable in helping to maintain body activity.

The same general idea of *gradual restoration of the patient's interests to environmental matters* holds true in the depressive stage as it does in the manic. Hence, careful psychiatric nursing and occupational treatment are highly desirable while the patient is

in the hospital—to be followed by assistance of the social service department when he leaves the hospital. Finally, when he is restored to his former self, deep psychotherapy may give excellent results: *it should always be tried*, not necessarily because of the likelihood of another attack, but *because usually psychotherapy can appreciably raise his former level adjustment*.

One cannot say with too much certainty whether the individual will or will not have a second attack, yet it is well to bear in mind that *when patients have their first attack* at about the age of thirty-five the chances for a subsequent attack are considerably reduced—as against those who develop manic-depressive psychosis earlier than in their thirty-fifth year. Moreover, those who experience the psychosis in the later years of life, say, from the age fifty on, ordinarily have the depressive phase, which commonly lasts for several years running and from which complete recovery is not achieved as a rule.

Schizophrenia (Dementia Praecox)

To the popular mind the term *schizophrenia* has a frightening effect, into which go all the impressions that one has about insanity. The man in the street shudders when he hears the word used and, if he is inclined to be nervous, he thinks of the worst condition possible. His chances, however, of becoming schizophrenic are very slim. They are a little less than one per cent. Expressed another way, it is known that only 85 out of the general population of 10,000 develop this illness to the extent of requiring hospitalization. The dread of the disorder, therefore, should not arise from the statistical probability, though there is every good reason to fear the consequences when they arise. Once past thirty and free from schizophrenia, one need hardly worry about the coming years, as thereafter the risks from it grow progressively slimmer and become almost negligible after fifty. This information should be constantly in mind when reading the succeeding pages on schizophrenia, lest one somehow come to feel that he is learning something about a mental disorder that is very common.

What makes schizophrenia seem like such a vast problem is the fact that some eighty per cent of those entering a psychiatric hospital remain there for the rest of their lives. This means that over the years the accumulated total of schizophrenic patients grows steadily, though in the general population they constitute less than the one per cent limit.

That schizophrenia is a direful condition cannot be gainsaid, more direful in its full development to behold than to have. The average patient with this disorder suffers neither pain nor un-

happiness, once the condition is fully developed. On the contrary, in terms of personal happiness, their general lot, morbid as that may seem, is far above that of the average individual. The psychoneurotic individual out in the environment, is in greatest anguish struggling valiantly to maintain some semblance of peace of mind. On the other hand, once having become a "victim," the schizophrenic patient is contented. There are exceptions to the rule, but they are infrequent.

From a purely objective point of view, it is pathetic to see fine individuals taken out of normal ways of living and put amid animalistic and primitive ways. The contrasts between their usual modes of adaptation and the abnormal ones are very striking in most instances.

Until we know more about schizophrenia we can best understand it today as *a way of living in a world apart*. The individual who is unable to free his emotions from their primitive and infantile attachments finally has to give up trying to be a part of the milieu in which he lives. It may not be incorrect to say that to him the primitive way of living is far more compelling than the real environment in which he exists.

Of the group as a whole, some eighty per cent are quiet, seclusive, shut-in, prior to the development of schizophrenia. They are highly sensitive to the environment, withdrawing quickly from it, because to them it is harsh and forbidding. Many of them are not even at ease with their own parents, who may be very kind and solicitous about them. *They are children who cannot make friends easily, and as they grow in years their emotional shut-inness becomes more apparent*. They may acquire one or two friendships with those of their own sex, but they usually steer clear of the other sex. Ordinarily they remain in positions inferior to those around them.

The name given to these individuals to designate their type of personality is *schizoidism*, which for practical purposes means *a splitting of the personality*. Perhaps it would be more exact to say that these individuals steer clear of their immediate surroundings, or that they never fully accept them. They are afraid of their en-

vironment; they do not want to go near it, for they regard it as dangerous.

As forms of defenses against the presumably hostile environment the individual may react in one or more of four different ways. He may (1) simply ignore not only the environment, but his instincts; (2) discard the environment entirely in favor of his instincts; (3) surrender his instincts over to the environment; or, (4) securely close both his mind and his body against the environment.

In what is to follow immediately, we hope merely to establish a general orientation with respect to the different ways which the quiet, reserved, highly imaginative and unrealistic individuals may unconsciously employ as their solution for the control of their inner, instinctual drives.

(1) *Simple Schizophrenia*. Just what factors may operate to bring about the state known as simple schizophrenia is unknown. From the mental point of view, however, it appears that the individual to whom this diagnosis is given, ignores his entire life—past, present and future. We use the term "ignore" as an expediency and not as a scientific fact. We do not know why this person does not show any essential ideas, experiences or drives. All we know is that he (or she) does not.

(2) *Hebephrenic Schizophrenia*. Some of the individuals are so alarmed by their surroundings that they shut their eyes to it and retreat into their own minds, so to speak, where they find an elaborate primitive world waiting to receive them. This fully developed world is the heritage from the distant past of mankind. It is the *racial heredity* of which we spoke in a previous chapter. It is in all of us, available as a place of refuge when the real world in which we live seems harsh.

It is in truth a fascinating castle in Spain, a seat of great authority, from which those who live in it can delusionally view the universe, control it, be very intimate with all the details of the universe, and, what is equally important, can lead a free and unhampered instinctive existence, in phantasy, of course. In this imaginary castle, the individual is omnipotent, omniscient; he is

at the same time the most *potent* of all males, the most fertile female.

Indeed, from the early years of life, the individual, who later becomes what we call schizophrenic, is familiar with the advantages of living in his or her phantasies as compared with the disadvantages of struggling through the environment without achieving much distinction. It is, perhaps, incorrect to assume that the individual has any free play in the choice of the one or the other way of living. This point of view seems all the more plausible when we realize that when the time comes for the individual to take one course or the other, almost invariably he makes a frantic and all too frequently futile effort to take the path of natural living. But, the forces of his instincts, endowed with a life of ease, grandeur and power, are far superior to the hardships, plainness, and weakness which reality offers. The schizophrenic has no choice; he is forced into the schizophrenic way of living.

(3) *Paranoid Schizophrenia*. On their way to schizophrenia some individuals fight valiantly against the false offerings of security and power, and they succeed to some extent. They are the ones who reconstruct reality to conform with their unconscious drives. This is not a conscious, deliberate process on their part. It is done by their unconscious, which directs the patient to interpret reality as the unconscious would "wish" it to be. Fundamentally, this process is observable in almost all people, who, at one time or another see what they want to see, hear what they want to hear. For the time being, conscious, critical judgment is absent. Certain schizophrenic individuals show this form of mental activity on a grand scale since almost the whole of reality is misconstrued by them. But, by *them* we mean more exactly "their unconscious, instinctual drives."

When the elements of the unconscious circumvent the conscious ego and, so to speak, become a part of the environment, the individual's conscious ego views this combination of his instincts with the environment as an unholy alliance, to which he vehemently objects. He is justified when he protests against the environmental freedom accorded the instincts. It is all, of course, a mental

"trick," since his instincts are not in the environment; he is deluded into believing that they are. *The mental process by which the instincts are thus thrown upon his conceptions of the environment is called projection.*

(4) *Catatonic Schizophrenia.* There are some individuals, who, feeling that the environment is attacking them, actively shut and lock themselves within themselves. They shut off their mind and body more or less completely and literally from the environment. They keep their eyes shut, keep the lips tightly pressed together, and are mute; their whole body is rigid and rolled into a ball or, as we say, they are flexed at all joints.

However, this same individual may take a stand opposite to the foregoing. He may be completely responsive to all environmental stimuli, or, even without any active stimulation from it, he may be the mirror image of his surroundings.

This is the general over-all situation in schizophrenia and the description lends belief to the concept that schizophrenia represents a form of living. Whatever other factors may enter to produce it are not known to us yet, but at present it is not appropriate to refer to it as a disease, certainly not in the commonly accepted sense of that term. The most eminent scientific minds, concentrated indefatigably upon it, are still without any evidence of reliable organic correlations between the symptoms of schizophrenia and organic changes. There have been many inklings, but they have not yet given a hint of solution. The best we can do today is to start with the known facts, which, we realize, do not go back to ultimate causes, and to work industriously from those facts backward. The facts we have are significant, if not final. They give us a point of view which in many instances can be put to excellent use from the standpoint of preventing schizophrenia and, at times, of curing or ameliorating it.

For descriptive purposes psychiatrists have divided schizophrenic patients into four main groups on the basis of preponderance of given symptoms. This subdivision is in the interests of convenience and, therefore, cannot have precise application to the many variations that are met with in practice.

I. SIMPLE TYPE

The outstanding characteristic of the *simple form* of schizophrenia is *inertia*, both in the mental and physical spheres. From early childhood onward, lack of interests and energy is particularly noticeable. Such children are relatively indifferent to toys, do not romp around and play, nor do they share the enthusiasms that the parents may exhibit in their presence. They seem to be passive to most events about them, failing to show glee when the parents play with them or present them with a gift that would make other children jump with joy. There is not much that attracts their attention, at home or outside of it.

In late infancy many of these children like to have stories read to them; at least they do not protest. Nor do they ask questions as the story is read. They do not volunteer to repeat a story, but when asked, they may recount it, though not very enthusiastically.

If well-endowed intellectually, they are given to reading, preferring stories with action in them—something that they do not possess, but apparently long for. The habit of reading grows with the years, though they do not seem to gain by reading; it does not act as an incentive for them; they do not emulate the characters about whom they read, as the normal youngster so often does.

They are gentle and mild in school, usually doing their homework on time and faithfully, though they do not generally capitalize on scholarship. They are students without drive. They do not look for posts of honor in class, are not envious of those who are ahead, but seem to be contented to do things in their own simple way. When prodded into activity, they show mere resentment.

As they advance through the later grades in school they ordinarily slump in scholarship, doing just about enough to pass their subjects. Their physical slowness and awkwardness is particularly noticeable in the gymnasium; they go through drills with the same passivity that characterizes them in other fields. They do not try to make any of the school teams. Outside of school, they seem to tire easily. School picnics or hikes hold no attraction for them, nor do dances or parties.

By the time they get into high school the additional work required begins to weigh heavily on them, and brings reduced efficiency until they finally peter out completely at about the second or third year of high school. Living without plans, they make no move to pick up new interests to fill the void left by absence of school work. They idle about the house, go to bed at any hour, sleep until noon or later. There may or may not be carelessness in personal appearance and lack of neatness and cleanliness about their belongings.

When the members of the family finally decide they must act for the patient, they get together for a discussion about what to do. The lad is present, but throughout the council he sits without making comment; perhaps he shrugs a shoulder in response to a question. They try to draw him out in order to determine what he would like to do, but a complete scanning of various kinds of endeavors evokes no enthusiasm from him. They try in vain to encourage him to return to school, because he has had experience in studying; they go to lengths to impress upon him the value of education in this competitive world. However, they soon become aware that he quickly discourages any thoughts of a professional career; they know this, not from anything he says—because he does not say anything—but from a look which by this time they have learned so well to understand.

The conversation turns to office work of some kind. Would he like to be a typist? "Maybe," he answers, "but there is no future in it." They are glad to hear the idea of a future from him. Maybe he will offer some comments about it. It seems that he tries. He starts a sentence, but it tapers off into nothingness. He makes a new start, but it ends in squirming. Father's patience is beginning to sap; mother senses it, turns to him knowingly and, without losing his temper—that was agreed upon several days before, when they planned this conference—father enters upon a long discussion on the value of having a purpose in life. Quotations from authoritative sources on the philosophy of purposeful living are given intensively consideration by the father and are re-enforced by nods from the mother, while son picks at his fingernails. Mother looks

on this vacation, not unless he wanted to. He rejects this offer by his passivity.

The parents are at their wits' ends. Perhaps, they say, he is sick, but he has no complaints whatever. In fact, he has never had any serious illness; his physical health record is excellent. They begin to wonder whether to be sick one has to feel sick. Then their thoughts turn to the endocrine glands. They can be out of order without the patient knowing or feeling any ill effects. Finally they take him to the family physician who reports that all examinations and tests fail to reveal any deviation from the normal. At their suggestion he is sent to a specialist in endocrine matters, who finds nothing positive, yet suggests that there is no harm and there may be some good in trying this or that endocrine product. Nothing essential is noticed after a few months of treatment.

Perhaps a psychiatrist can throw some light on the subject? Extensive psychiatric examinations are made. The patient's condition fits into the classification known as *simple schizophrenia*. The psychiatrist searches painstakingly for an emotion that can be grasped for purposes of treatment, but finds that each slender filament or emotion snaps off quickly, just as it had done with the parents. The psychiatrist's most minute investigations fail to reveal that the boy has any wishes, at least none that has any basis in directing possible actions. A survey of his dreams seems to offer clues for investigation, but the patient is as indifferent to them as he is to all else. The best efforts of the psychiatrist are useless.

This unfortunately is the picture of the severer forms of simple schizophrenia. The energy of the patient, at least the manifestations of energy, are extremely meager, seeming to be just about enough to keep the patient's physique running under minimum activity. In a strict sense there is nothing *psychiatric* about him, if by that term we mean evidences of abnormal use of emotions and ideas. His is a puzzling mental and physical state, at the moment best understood in terms of *energy*.

The question of energy, its origin and distribution in the body, still baffles the best minds in medicine. It has been receiving attention over the past few decades from the school of medical research

called *constitutional medicine*. Many interesting leads have been developed, but up to the present none has found acceptance in cases of simple schizophrenia.

Not all simple schizophrenic individuals have the low amount of energy depicted in this case, though all of them appear to have poor endowment in that respect. Those who have more may put it into the performance of menial tasks, which do not require much output of energy. In others the energy may appear as mild nervousness, particularly of the physical type. Still others, when stimulated beyond their capacity, may energize their minds, showing resentfulness to the efforts of others to stir them into activity or they may become delusional and hallucinatory. When the latter takes place, the symptoms are not well-developed, as a rule. The delusions and hallucinations have no systematic growth as they have in other schizophrenic individuals; nor are they sustained. One gets the impression that they are expedencies designed to fend off the opposition and abandoned as soon as they have served that purpose. In putting it that way, it is not intended to give the patient conscious responsibility for the appearance of the symptoms.

The individual whom we call a simple schizophrenic may not be schizophrenic at all. In the early years of psychiatry he was not included in psychiatric classifications. It is not improbable that he got into the field, because there was no other place in the medical realm into which he seemed to fit. Until he is better understood he should be looked upon as the joint problem of internal medicine and psychiatry.

II. PARANOID TYPE

The general psychiatric significance of the concept *paranoid* has to do with the *tendency* on the individual's part to blame others for the troubles he experiences. Literally the term *paranoia* means being "off" the mind. When introduced centuries ago, it referred to those individuals whose mental abnormalities seemed to be genuinely of mental origin, that is, the question of organic etiology

never gained more than secondary consideration. But, in the earlier centuries, a great variety of mental conditions were subsumed under this heading, until in 1764 Vogel gave the term the more definite connotation that it bears today. We think of the *paranoid patient* as one who *has delusions of persecution*, as one who systematically constructs a whole set of false accusations against his fellow man, taking, as a rule, several years to complete the delusional system. One gets the feeling that the patient's abnormality is a slow outgrowth of personality factors and the feeling is enhanced by the fact that ordinarily these individuals are strong and healthy from the physical point of view. Often they are the acme of physical perfection and excellence.

The usual character traits out of which the paranoid reaction develops are reasonably well-defined, although there are various grades of intensity that stamp the individuals of this group.

The potentially paranoid subject is ordinarily not as shut-in, not as schizoid as are the other members of the schizophrenic class. While it is true that he splits off, so to speak, from the environment, it must be understood that, with the exceptions to be noted later, the paranoid patient quarrels with the environment as it actually is and in his own mind sees it from his delusional point of view. This means that he delusionally reconstructs it to correspond with his inner complexes. He accomplishes that by the mental mechanism called *projection*; he unwittingly disowns whatever he wishes to disown by casting his undesirable impulses upon others and then by objecting to them as they seem to come from others. This is simply the well-known process of blaming others for our own faults, a condition that can grow so excessively as to incapacitate the person completely and produce varying grades of paranoid conditions from constant jealousy to the most deeply regressive infantile form of adaptation.

Jealousy and envy are normal traits of infancy and childhood. The babe wants mother's exclusive attention and is peevish when she gives attention to others, whether they are children or adults. He (or she; paranoid conditions are about equally distributed between the two sexes) clings to her to check her from diverting attention from him; often he is particularly insistent in his de-

mands. Parents should recognize that *this is a normal characteristic of almost all children* and that in many instances *the final solution depends upon how the parents handle the problem.*

Because the beginning of treatment starts with these early manifestations, it is highly important that parents know reasonably well how to react to a child's jealousy. In the first place there should be *no great hurry* to train the child away from jealousy. If the child is forced to relinquish the trait at too tender an age and if it is done impetuously, the trait is not abandoned, but engulfed in disappointment and hate. The keynote of the successful management of the jealousy of children is *calm reasoning* extended *over a period of several years.* This may sound like a severe task, which it is not, because it is no different than the time and attention that is allowed for physical growth from infancy to maturity or for intellectual progress from the kindergarten to high school. What parents do not commonly understand is that *the forming of character is also a slow process* and that *character can be remarkably distorted by neglect or oversolicitude or by forcing.*

We overlook the fact that *it takes time to make a mother and a father.* We realize the value of preparing the prospective mother for the physical ordeal, but to date she is given only *a few general instructions on the psychological significance of having a child.* Frequently the most that she can expect from her husband, her doctor, her friends is congratulations and, while such expressions are polite, *they do not at all tell her what it means to have a baby.*

It means among other things that, if she is to bring the child up properly, *for the next several years she must radically change her plans for living.* If she is young and relatively immature and has not yet achieved her general aims, it is by no means an easy task to relinquish her ambitions. That in itself is a serious undertaking; it is a real frustration. The average man would recognize it all too vividly, if halfway up to his goal he were slowed down progressively and finally stopped completely. Because it happens to women, so to say, as an act of nature, the change is no less significant on that account.

The prospective mother does more than stop. She has to re-pace

the very path over which she has so laboriously trodden, namely infancy, childhood, maturity. *The wife's pregnancy is normally an incentive that pushes the husband's interests onward: he grows up. His wife grows down.* Having a baby compels her regression, if she follows the natural course of motherhood. That is one reason why pregnancy and motherhood are difficult barriers in the life of any mother, unless she knows and accepts the conditions of both.

The new mother must go down to the level of her newborn baby and she must re-enact all over again the very physical and psychological states from which she was glad to grow away. *If she cannot go back to the level of her baby, she cannot give it the psychological nourishment that the baby needs every bit as much as it needs food and warmth. The greatest single item of psychological necessity for the child is the giving and taking of love and affection.* Almost every infant is ready to give love and to give it in abundance. How mother takes this offering determines the fate of the child as a human being. We do not mean to overlook father, for he, too, plays a very significant role. It is the combination of the two that helps greatly to shape the infant's mind. We are following the mother, not simply as a mother, but as one of the molds—usually the more powerful—that form the character of the child.

We want to keep our observations to the point in question, namely, the management of jealousy in the child, but since it usually, but not always, depends upon the psychological make-up of the parents, we must first look to them for the solution. There is little that is more damaging to the child's mind than an emotionally neglectful mother or father or both. *The mother who will not forsake her career as a businesswoman or as a woman in some environmental pursuit, perhaps it is her position in society, may create an injury in the child's life that may leave a large scar.* We should not believe that mother can be held fully responsible, but for the moment we are emphasizing her part. Nor should we forget that the child has its own endowment, its own potentialities. It is the combination of child and parents; it is this bilateral aspect of familyhood that must always engage our attention.

Not a few of the psychiatric patients we are called upon to treat are brought up in a private orphanage, with the maid as the managing director and the parents as the stockholders. This is not just a figure of speech, it is too frequently a tragic arrangement. *The best maid is still not the mother or father. She is like a legally adopted mother.* There can be no complaint about her as such, but the extent to which her services are called upon may be greatly important. A beautiful home may not have the atmosphere of a home at all, but that of a private hotel. Another home is a penitentiary; a third may be a nursery; a fourth a hospital. We actually encounter such homes; they are not theoretical fictions.

The jealous child who is not properly trained to know what he (*all the following applies just as fully to a girl*) is normally entitled to expect, the child who is not slowly taught that in his upward growth he must learn to be a part of the environment in which he finds himself, may extend the jealous spirit from his parents to his teachers and classmates. He feels that he is being discriminated against. His teachers do not like him, he believes, and for that reason give him lower marks than he deserves. He begins to compare his earnestness with a fellow classmate's carelessness and he wonders why the teacher is partial to the other fellow. He begins to dislike the other fellow and perhaps thinks that the other fellow has dropped some disparaging remarks about him to the teacher. Otherwise, why did the teacher interrogate him so minutely about a fracas that took place while the teacher was out of the room for a few minutes? The questioning bothered the boy no end; he thought of it for weeks thereafter.

Ordinarily this jealous boy is aloof to his classmates, but he does not think he is the distant one; *they* are distant and cool to him—is his opinion. The inclination to blame others is already in evidence. He does not seek to join a group, but he believes they do not want him. He cannot understand why he, a sober, serious student, is not invited to join the history club or the debating society or some other scholastic unit. He guesses they do not like him. Or when he is invited he shares *only* with scholarship, not with

sociability. He is a sad, lonely figure, but he is aggressive and determined that they shall recognize his aptitudes, even if he has to force them upon his classmates.

However, his mind is patterned on rebuff, and no matter how much he succeeds intellectually, he is emotionally restrained. He is always looking for something unattainable. He has no clear-cut idea of what it is, but his classmates who could easily tell him, realize that he would resent their opinion. They could tell him that he is not a boy among boys, that he does not take kidding in the light-hearted manner in which it is given, that he always seems to have a chip on his shoulder, and that he reduces to a logical conclusion all comments made to him. The other day a fellow humorously remarked that he could prove the moon was made of green cheese; others laughed momentarily and forgot about it. But the jealous boy thought the statement was a disguised allusion to his greenness, and he felt hurt and angry. Like a jealous fellow he never tried to ask the boy what he meant. He was certain he knew without having to ask. Even if he should ask, he was sure the boy would not tell the truth, but would just say something to be polite, which would make it worse.

This young man shows in a number of ways that he cannot get along with people. He is commonly known as a crank, though at heart he does not mean to be one. He is resentful, because he feels the world is against him; he has the firm conviction that no matter how hard he should try, nobody will ever care for him.

When he comes into young manhood, he is acutely bothered by the re-awakening of his sexuality. When he masturbates, he has a keen sense of guilt, as if he had committed an unpardonable sin. Erroneously he believes that he stands alone in the practice and that masturbation will weaken his mind. Because he does not confide in anyone and because he shuns the company of boys who seem degrading to him—they swear and tell dirty stories—he becomes firmly convinced that the practice will result in insanity. He tries vigorously to escape from sexual feelings and finally succeeds in repressing them. He thinks about honest, clean, normal topics. In truth he is a clean-cut lad, too finely so.

When he begins to go out with girls he is very mannerly and reserved. Propriety is the keynote of his attitude towards them. Conversations lean too heavily in the direction of scholarship. When the girl moves up close to him, puts her hand into his and strikes a pose that calls for a kiss, he is uneasy and gently withdraws. He wonders whether she has not had a "past." The thought that maybe she has had a love affair before she met him becomes the truth to him, for he interprets her initiative in love-making as aggression. He reasons with himself that he does not know girls and therefore is easy prey for their wiles and deceit.

Thoughts on her suspected duplicity mount in him, creating panic. He is really bewildered; he cannot shake the suspicion from his mind. He is a sick young man, every whit as sick as if he had a disabling physical disease. He may feel queer throughout the body; appetite may become poor; sleep fitful. He may begin to feel that the origin of his troubles is physical in nature and he may become a food faddist. A little later he takes up exercises for the purpose of body-building. He regulates his daily habits with great care.

To the casual observer there does not seem to be much wrong with him. Indeed, because he avoids most people, his plight is not realized by them. He is suffering, however, far more than anyone can see.

When he enters college he applies himself assiduously to scholarship. He is a likable fellow, honest, sincere, upright, but he is progressively shutting himself up. Mental tensions are often diverted into physical channels. *He finally goes to a physician, but not until he has more or less thoroughly disguised his personality troubles with what appears to be a physical disease.* Though the physician finds nothing of an organic nature, save excellent health, he may ill-advisedly treat the patient's complaints as if they constituted an organic disease. He puts the patient on a diet, re-enforced with vitamins, and gives him injections of an endocrine preparation. This course of treatment is given throughout the college year. The patient is hopeful but his symptoms remain the same. *There are no known medicaments to counteract suspicions and its consequences.*

Fortunately, however, he may go to another physician, who sees the patient as a human being, as a work-machine completely subordinated to his intellectual self, as a stoical fellow to whom human emotions are anathema. It would have been better had this young man been treated at some earlier age, yet the chances for cure of his personality disruption at this time are still excellent, first, because he has many fine assets that can be put to good service, second—and more important—his mental troubles are only tentatively disguised as physical symptoms.

Investigation and treatment of his personality troubles should certainly not be delayed beyond this point, because he is already a sick person. His efficiency as a human being is already curtailed to an appreciable extent and if his ailments went no further he would still go through life with an unnecessary burdensome handicap.

Assuming that he is not seen by one who understands the nature of his troubles, which at this stage of his illness might take the name of *psychosomatic disorder*, he may be able to go on to graduation from college by dint of application to studies. *He pays very dearly for his education, because he leaves college as a student, not as a man.* In the meantime he has learned very little about people and less about himself. The spirit of living has been entombed in the pursuit of scholarship. To him the world is a field of scholastic competition, which from time to time is disrupted by petty jealousies and suspicions. On his path to education men have not treated him fairly, so he believes, because often they have subordinated logical thinking to the base emotions, implying to him that they have tried to lure him away from the good and to the evil. In the beginning he pitied the young men who sought what he called a bestial outlet. Later he avoided them whenever he could, but there were times when he had to be in their company. Then he had to listen to their stories of romantic conquests, which annoyed him no end, but he was thoroughly irked by their sexual jokes, particularly if they were on a homosexual theme. He knew full-well that they had him in mind when talking of homosexuality and of effeminate men. Frequently he was tempted to have it out with them for their innuendoes, but he did not, because they would be

able to convince others that there was no reference to him whatever, thus leaving him more embarrassed than ever. They were clever men, he argued to himself, and in their subtle ways were attempting to make him immoral.

He plunges more heavily into scholarship and in the subsequent years he is known among his associates as an excessively serious, studious man, who may some day make a mark for himself in his chosen field. They would like to learn from him, because he has so many facts at his fingertips, but they will not ask him, not when they recall that several tried it in the last few months and were politely rebuffed. They did not know that he thought they were attempting to get information from him so that they would get the promotion for which he was looking. Why, he asked himself, why did they start asking him questions just when a promotion was in the offing? He knew it was just another trick to keep him down and humiliate him. Before approaching him, did not a fellow worker plainly wink knowingly at another? And why does someone always follow him to the men's room? Only the other day a fellow started a conversation with him, when they were in the men's room, but the patient knew what was up; that is why he answered so brusquely. He was not going to be drawn into questionable conduct by any ostensibly innocent conversation. If they wanted to talk to him, they could do it right out in the open. He knew the evils that are veiled in pleasantries.

Jealousy has by this time grown into animosity and boundless suspicion. While waiting for a bus the other day, he was angered when a man standing nearby expressed the opinion that all public services were of a low order and going to ruin. The patient eyed the speaker warily and the words "low order, going to ruin" kept recurring to him. Men are vicious and unclean, he concluded. Can they not see that they cannot tempt him, even if they do *induce a stranger to lure him into indecency*? He knows that his enemies—they are enemies now—are powerful and resourceful and that they will go to any length to subdue him. The persecutory delusions are now well-developed.

Over the last few years he has been working on a secret project

for a mechanical device that should revolutionize the industry. At all times he has been exceedingly careful not to drop a hint about the matter. How is it, though, that several times during the past year, several workers have asked him why some of the engineers could not invent a machine that could do the work of twenty men? And when they suggested in their subtle but casual way that perhaps someone is working this moment on such a machine, that was enough for the patient to conclude that they are spying on him. A long series of suspicions grows out of the other fellow's comment. He carefully checks back. He first made notes on the project on January 8, three years ago. He was sure he made them only in his room at home, with the shades drawn. While he was then making the notes, the telephone rang and he was called out into the hall to answer it. Somebody had the wrong number. The man who called him to answer the telephone—did he sneak in to read the notes? The patient remained unconvinced when days later he spoke to the man about the telephone call only to get the "subterfuge" that the man could not understand the name clearly, but it sounded to him somewhat like the patient's name.

The patient's suspicions are firm on a host of similar incidents, all of which to him strengthen the conviction that men have stolen the secret of his invention. He was robbed of something highly important that would benefit man, something intensely personal to him, something extremely private that only he himself knew about. His private life was filched from him by men.

He is wrathful, when later a fairly close replica of his prospective invention appears on the market. He presents his case to a lawyer who, upon investigation, advises his client that he has no cause for action. But he is not satisfied, even with the same opinion from a half dozen other reputable lawyers.

He is now a patient with *litigious paranoia*, also known in psychiatric literature as *inventive paranoia*. The vast majority of such patients are never seen by a psychiatrist. After many futile attempts to engage the services of lawyers in court action, they retire into their personal grievances, as a rule clutching at them for the rest of their days. They are alert, keen people, always holding a

grudge, always suspicious of others; but they are reliable and efficient workers, meticulous to a fault, honest beyond reason, and obedient to authority in a purely literal sort of way.

The litigious paranoiac may develop his paranoia along other lines, the chief of which has to do with the question of inheritance. These individuals amass a wealth of evidence that they misinterpret to mean that a rich relative left them a vast estate, which was diverted to others through the machinations of persecutors. Also, likewise, the false premise of having been *robbed of something valuable* is in evidence in these individuals.

Paranoia represents one of the outgrowths of the jealous personality. It is said to be more common among men than among women. One of the characteristic features has to do with the fact that in paranoid states *men are the persecutors of men, women of women.* In other words, the conflict of the patient is waged on a highly disguised suigenderistic (i.e., pertaining to one's own gender) basis, with a large element of narcissism (self-interest). Paranoia is thus seen to be one of the higher levels of abnormal methods of adaptation, standing between morbid jealousy and the paranoid form of schizophrenia.

The paranoiac who gets occasionally into the office of a psychiatrist by reason of his paranoia *does not respond favorably to any form of treatment, medicinal or mental.* Fortunately many of them spontaneously lose their acute symptoms, still retaining their jealous, begrudging disposition, which makes them appear as *character psychoses* in contradistinction to *character neuroses*.

Why some jealous individuals take the route of paranoia while others, if they are to become mentally sick, take that of schizophrenia is not known. Perhaps several factors may enter. The intensity of jealousy, combined with a strong leaning to live alone emotionally, may be a contributing element. Many patients are seen who have transitory delusions of persecution of such intensity as to require temporary hospitalization. They are forced by their delusions to relinquish all environmental achievements. From a diagnostic point of view, they fall into the group called *paranoid condition*. Generally they are susceptible to psychotherapy, to a

combination of the psychobiologic and psychoanalytic methods. Many of them seek the assistance of the psychiatrist, showing thereby that to a certain extent they are aware of the abnormality of their mental state.

Still other jealous individuals pass from jealousy to delusions of persecution and on to hallucinations of persecution, retaining a measure of each. Those who do so are said to have the *paranoid form of schizophrenia*. Many of them withdraw more or less completely from all forms of environmental activity and stay in a psychiatric hospital for the duration of their illness.

The early delusions of persecution in the paranoid type of schizophrenia are not much different from those seen in patients with paranoia. Gradually, however, the delusions change their appearance. The patient comes to believe that men are persecuting him for purposes of enticing him into acts of indecency. He thinks that his persecutors want to use him as they would a woman for sexual enjoyment; when, at his place of employment, men gather for a tête-à-tête, he knows for sure that they are planning to gang up on him in an immoral way. When an employee, passing his desk, greets him, he suspects the greeting is a signal to the others that the time is ripe to "get" him. Besides, the greeting was a mocking reference to his effeminacy, meaning "how are you, sissy?"

He may sooner or later develop more vivid *delusions of reference*, which are *misinterpretations* of actual things seen or heard. On his way to work he saw a man spit into the gutter. It was done as a symbol of contempt for the patient's alleged immorality. Another man blew his nose, thus bringing the idea of dirtiness to the patient's mind. A third man crossed the street just before reaching him, for no other reason than to signify his aversion to the patient. A fourth wore a red necktie as a subtle form of enticement. The patient is beginning to see the whole environment converging upon him with all its obnoxious impulses. He is unwittingly *reconstructing his surroundings* on the basis of his unconscious homosexual urges, which he does not recognize, but against which he struggles, as they appear to him to come from the environment.

While *paranoid schizophrenia* is based essentially on homosexual

ality, the average paranoid patient never was and is not overtly homosexual. He has no such wishes in any conscious sense of the word. By the homosexuality within him—which he does not view as coming from himself, but from others, through the mental process of *projection*—he is perturbed as keenly as any normal person is, when pestered by homosexual overtures.

He begins to feel sure that he hears his persecutors first talking among themselves about what they intend to do with him: they are going to make him be their woman. Thus far he has successfully warded off their nefarious suggestions and in so doing he has gained strength from conscious righteousness. His powers are further increased when he effectually refuses to heed their direct voices. Now the persecutors engage him with all sorts of dirty names and he may yell back that he will have nothing to do with them. In public he may restrain himself from yelling, but he may fervently say "no" to them, by a gesture of rejection. Thus he reacts to *auditory hallucinations* of persecution.

When he goes into a restaurant the food tastes peculiar. The persecutors inveigled the chef, so the patient believes, to put nasty stuff into his food. He calls it poisonous, though it does not poison him. It is a nauseating substance. This form of persecution takes the name *gustatory* (relating to taste) *hallucinations*. He is disgusted with his persecutors and rejects their baneful influences as they appear in the food.

The persecutors keep on trying. They blow disagreeable body odors around him, and he is furious at them. These are *olfactory* (pertaining to smell) *hallucinations*.

They play electrical waves upon his body, particularly upon his privates. The persecutors operate the electrical machine often from great distances. He is then said to have *tactile* (touch) *hallucinations*.

Sometimes, though this is not usual, he sees his would-be persecutors. It is not a *visual hallucination*, unless he believes he sees someone who is not there. In other words, a *hallucination* of any kind is a *sense perception*, that is, something that the patient hears or tastes or smells or feels or sees—a sense perception for which

there is no appropriate stimulus from reality, that is, from the environment. In the patient's mind, there certainly does not seem to be any doubt that he experiences the sensation, so completely real is it to him. It appears, however, that he explains his hallucinatory sensations as he explains his delusions (a false *belief* to which there is no corresponding reality), by a conviction that the feelings and beliefs proceed from others, not from him.

Throughout the persecution, the patient all the time gathers strength with which to fend off the opposition. He is happy with his power, glories in it. To the observer it appears very odd that this patient is happy in the midst of vile persecution.

Psychiatrists call this apparent inconsistency *splitting of the personality*, and say that it shows *emotional splitting*. In a sense it does, because it demonstrates the *defusion* of the emotions, the tender, erotic ones going over more or less completely to the strength of righteousness, while the aggressive ones serve to attack the acts of degradation which presumably spring from his persecutors.

One of several courses is now possible. (1) A few of these patients recover, losing all their symptoms and being restored to their former quiet selves, though the *likelihood of a recurrence of their symptoms is always present*. (2) Another small number remain essentially in the condition just described. (3) *The majority regress still further.*

The struggle between good and evil usually ends in "victory" for the good. The overwhelming power achieved by the patient engenders a sense of omnipotence, particularly when he feels that he is able to resist the temptations that come to him from the entire world. Now there is but a short step to the conviction that he is The Redeemer and in his delusional way, through the magic of belief, he is the sole power over the universe. The persecutors may disappear and the patient is free to run the world. He not only causes day and night to come at his wishful command, he controls all movement in the universe; he is responsible for all atmospheric conditions, for the whole of nature. *He is the world and the world is he.* This *cosmic identification* is associated with the delusion that

as the creator of all things he gives birth to all living creatures from man down. He does so entirely by himself, for in his regression, when he relinquished the struggle against evil, that is, against homosexuality, he became a female, while still retaining maleness. He has regressed to the biological state called *parthenogenesis*. This is but another way of saying that he eventually *takes himself as the object of all his instincts*. He has at last achieved delusionally what he could never accomplish in reality: to be at once himself, as well as his mother and father, all in a total and universal omnipotence founded on his instincts. He is the Godhead, the threefold personality of the one divine being.

III. THE HEBEPHRENIC TYPE

The term *hebephrenia* literally means the mind of youth; as a psychiatric expression it is used to denote what was formerly known as adolescent insanity. Today it is a subdivision of *schizophrenia*, generally having its onset in early adolescence. It is essentially a more or less rapid decline to an infantile mode of living, together with many mental phenomena that have remarkably close resemblance to primitive mentality.

The child who later goes into a state of hebephrenia is ordinarily intensely shut-in, the condition of *schizoidism* often becoming very evident in the first years of life. There is usually great shyness and more or less complete dependence upon the mother and father throughout the years of infancy and childhood, up to the advent of manhood. It is extremely difficult for the mother to wean the child from the breast, to get him to feed himself at the table, to encourage him to dress and wash himself. *At his school age, she may still be doing almost all the things for him that she did when he was six months old.*

In school he is remarkably shy and seclusive. For a number of years mother has to take him to and from school and she has to help him continuously with his homework. He is so *dependent and lacking in initiative* that the school authorities may believe him to be intellectually defective. Some children of this type are, but the

majority have an average or better than average intellectual capacity.

He (or she; both sexes are about equally represented) is *highly imaginative*, often fantastically so, and this imaginative attribute does not diminish much with the years. He does not play freely with others; rather, he is preoccupied with his *daydreaming*. His mind is always somewhere else, living with the characters, often caricatures, of his fancies. *He is his own love object from the start and continues to be so* as the years go on. Because of this he is unable to extend his interests to outside matters. These children absorb very little from the environment.

Not all of the children who later become hebephrenic are quite so shut-in, but it is unusual to find one who is not definitely of the schizoid type. When they do gain some external interest, it is commonly along lanes of scholarship.

As in other schizophrenic types, *regression is a central phenomenon*, but the territory over which the hebephrenic patient must regress is narrow. He does not regress from the adult level of socialization for the simple reason that he has never attained that level; the same reasoning is true for the stage of marriage or other forms of affiliation with the opposite sex. The potentially hebephrenic youngster has the meagerest associations with girls. There are occasional exceptions to the rule, but even then the hebephrenic is essentially a self-contained and self-sufficient person. It is said that there is little or no *altrigenderism* in him. Nor does he regress from the members of his own gender, that is, from *suigenderism*, a level which he never attained in any substantial sort of way. Indeed, regression in hebephrenia has more academic than practical significance, because the patient retains his early narcissism with the attributes of primitive mentality added.

Among the earliest morbid symptoms is intensification of self-love, manifested by exaggerated preoccupation with himself. The hebephrenic child is greatly in love with himself, often spending hour after hour in self-adoration before the mirror—a remarkably close likeness of the pose struck by Narcissus. He dotes on what he conceives himself to be, not what he actually is, for he is totally

unmindful of his personal appearance. He does not bathe willingly, nor comb his hair, nor brush his teeth, nor dress. Mother has to do all these things for him, insofar as she can. His physique does not mean to him what it means to the average boy. In fact, his self-adulation is directed to his infantile, and greatly inflated, ego. When asked why he stands in front of the mirror for hours, he merely indicates that he sees himself, not, however, his physical self, but a noble and powerful self. Some of the patients actually assert that they have only a mind, not a body. The body is part of the mind's environment.

The patient has no natural interest in his body, though he uses his body extensively in the service of his ego. He believes himself to be both male and female. Because he possesses the primitive idea of oral impregnation, he eats voraciously with the idea that the more he eats the greater the number of babies he produces. He is incessantly populating the world. Closely connected with this idea is the belief that people are constantly being reincarnated through him: they are in him ready to be born. Furthermore, in his delusional way he regards the interior of his body as made up of people, with whom he is constantly in touch. The various organs of his body are people. That is why the patient says that he is talking to his heart or lungs or stomach, or other organs.

On the assumption that he is God—it is not an assumption to him—he maintains that *he is eternal*, that he has always existed and always will. *He is not only timeless but he is boundlessly spatial.* He is the space of the universe, ubiquitous. He is simultaneously *omnipresent*. This delusion of *cosmic identification* is expressed also in terms of the physical universe, for he believes himself to be the totality of nature. He is the sun, the moon, the stars; he is all the animate creatures and inanimate matter constituting the world and he demonstrates it to his own satisfaction through the simple expediency of *magical thinking*. When he thinks he is a tree, he is a tree and he uses his body to re-enforce the idea. He simply stands erect, sways a little—and—he is a tree. By the magic of thought, he is a lion or any other animal; physically he acts the part by running around and making roar-like noises. Through the omnipotence of

thought he turns night into day, causes the universe to move or cease moving, creates war or peace, gives birth to millions of babies. He is omniscient, omnipotent, omnipresent.

There is no distinction in him between his ego and the universe. Psychiatrists say he does not distinguish between the "I" and the "not-I." Regression in this respect is well brought out when we know that in the early part of his illness he begins to drop the personal pronoun, I. Finally he no longer refers to himself in the first person singular, but uses his given name: John does this or that. Moreover, his allusions to himself as John lose all personal qualities. Eventually the third person singular is abandoned in favor of the unique combination of self with the universe. It is remarkable to witness the autonomy of the "ego" and its growth towards limitless omnipotence. But, he has no ego, as we commonly understand it. His mind now is only his *Id*, his instincts. There is no other human possession that can flourish so gigantically in virtue of its own aboriginal power.

To attain such a state of primitive all-powerfulness, the patient first passes through a phase of rebirth. In so doing he believes that he has gone back into his mother's womb. He acts the part as literally as he can, sometimes curling up in the fetal position of *universal flexion*. When he is in that position and asked what he is thinking, he may whine like an infant and say that he is in his mother. The entire dramatization is the reverse of the primitive ritual of rebirth that takes place in the ceremonies of puberty, when boys are converted from girls to men. The hebephrenic patient passes from whatever manhood he may have attained to bisexuality, to which is added potency and fertility of the highest order.

Because the patient exists only as an *Id*, so to say, he is singularly unmindful of the real environment in which he lives. It might be said that his body is without feeling. He can remain outdoors in sub-zero temperatures without feeling it in the least. In hospitals, he rests against a steaming-hot radiator when he is nude, perhaps burning himself severely, before he is taken away by the nurse. Some are known to have gouged out their eyes with no more feeling than they would have if shelling a pea from its pod. In his delusions he

they express. They are as much surprised by their own thoughts as anyone could possibly be. But, they are also pleased. That is why they show "silly" grinning and laughter. Logically, however, it is not silly to feel grandiose when one is the universe.

They talk about being both male and female, about self-impregnation, about unlimited births, going back into the womb, being the universe and the God—all these thoughts issue from the patient's mind quite apart from any effort of his own. In the very beginning he is acutely alarmed by these impulses to which he subsequently yields. But, while they are developing, he stands helplessly by only to see himself engulfed by them.

There is another very interesting feature connected with the patient's primitive mind. As the realities of life are being replaced by the illogical and aboriginal tendencies, the nature of the language of the patient changes. He loses relevance and coherence as we commonly understand those properties of logic. The loss is due primarily to the appearance of the primitive inclination to express ideas in one or two words. It is common practice for the patient to *condense* a whole series of allied events into a single word or phrase, just as you and I might be stimulated into a train of thoughts by some word or idea that is significant to the train of thoughts. Psychiatrists call this *condensation*. Then when the patient connects several words, one each from separate series of events, the result sounds like a hodge-podge to which the technical term *neologism* is given. Some authorities refer to the result also as *scattered speech*. It is scattered and illogical when measured by civilized standards, but, under the guidance of knowledge of the primitive mind, it is clear and understandable. Even if he cannot speak it, the student of psychological anthropology can understand the language of many thousand years ago.

In addition to high condensation the primitive mind is characterized also by the formation of pictures, *perceptual images*, that take the place of ideas. Thus, in Sanskrit five is represented by the hand with its five fingers. The oldest languages are pictorial in nature and the language of the hebephrenic patient is heavily so.

A mental law has been formulated to express the transition from

the primitive to the civilized method of mental activity. It reads that *thought and language in their development change from feeling, concreteness and perception to reasoning, differentiation and abstraction*. From actual observation, free from interpretation, it appears that the hebephrenic patient provides an excellent example of the retracing of the foregoing law.

Save very few, the patients who regress to the level of primitive mentality, particularly those who do so by way of hebephrenia, fail to recover. The horrible scenes of animalistic existence that are served up to the public in newspapers and magazines are usually made from hebephrenic patients. They are pathetic figures, no doubt about that, yet it ought to be explained that of the total number of just one type of mental disorder, namely, schizophrenia, which constitutes about 25 per cent of the total annual admission rate to psychiatric hospitals, 52 per cent are classed as hebephrenic. It was previously mentioned that the chances of becoming a hospitalized patient with schizophrenia are about 85 in 10,000 of the population at large. If we take a little liberty with statistics, raising the 85 to 100 patients for purposes of presenting round numbers, it is not so difficult to remember that of the total number of schizophrenic patients admitted to the psychiatric hospitals of New York State approximately 8 per cent are classified as simple schizophrenia; 10 per cent as paranoid; 52 per cent as hebephrenic; and 25 per cent as catatonic. About 5 per cent are classed as "mixed." One's chances of becoming hebephrenic, therefore, are about one in two hundred or 1 out of 2 schizophrenic patients. As grievous as hebephrenia is, it certainly does not reach the numerical proportion that popular articles inferentially try to convey to the public, namely, that the wretched condition of hebephrenia is a random average sample of life in a psychiatric hospital.

IV. CATATONIC TYPE

The fourth subtype of schizophrenia is called *catatonia*, from the Greek, meaning *a state of lowered tension*. The word is intended to convey the idea that the tension of the general musculature is

lessened in this state, but the term was coined at a time when only the lowered tautness was described. As knowledge of the disorder was accumulated, it became clear that the same patient could show *increased* as well as decreased muscular tension, while in the interval between the two stages, there might be normal tension. At any rate *muscular tension is the most obvious, though not the most important, aspect of catatonic patients.*

The history of the patient before developing catatonia is the usual one of introversion, shut-inness, schizoidism, although for the group as a whole there seems to be less of it than there is in the other subdivisions of schizophrenia. The children who wend their way to catatonia exhibit rather early in life the tendency to stubbornness manifested through postures, gestures, immobility or exaggerated movements of the body. These children speak more with their muscles than with their mouths. When they do not want to see anything they shut the eyes tightly; against sounds they clamp their hands over their ears; they close the lips tightly when they do not want to talk; they plant their feet firmly when they refuse to walk or they sit down in defiance to efforts to budge them. Their bodies speak for them. This form of mental expression might be looked upon as a sort of *primitive psychosomatic "language."*

Usually they are timid children, *shrinking* from the environment, when they feel they might get hurt or embarrassed by it. Because they are easily hurt mentally, they approach new situations with considerable caution. They *withdraw* from aggressive situations. As they grow older, they seek quiet play with others, although they seldom have many friends. They are not found on the kids' football team and certainly very rarely, if at all, in neighborhood gang fights.

They are likable children, obedient to mildness, *recoiling* from harshness. But, they "have a will of their own," which mothers and fathers know all too well. When son does not want to go shopping with mother, she has to drag him along, and for her insistence, she often pays dearly in the coin of embarrassment. Son balks at the street door; mother kindly encourages him to join her; he does not move; she cajoles him, getting the same results. She takes him

gently by the hand, then moves firmly, finally she tugs him away. He runs ahead and sulks as he scrapes along.

He is a moody youngster, warm and cordial one moment, cold and distant the next. In the classroom he is ordinarily quiet and obedient, attentive to his work, but peevish with classmates who try to tease him. They do that quite often, more as an outlet for their own aggression than because they look for a "rise" from him. They sense that he is afraid and soon come to know that he will not fight back. Moreover, teasing him builds up feelings of their own physical superiority.

In almost all situations he is a retreator, withdrawing from positions which the normal boy would treat with indifference. He may also be afraid of the inanimate world about him—of weather conditions such as rain, wind, snow. Those who do not know this type of child cannot understand the dread that is sometimes engendered in him by the elements.

He is at all times a gentleman with girls, and picks the scholarly type of girl, for he is relatively at ease in such settings. Because he idealizes womanhood, he deems it improper and indecent to think of holding her hand, and feels startled when she slips her hand into his.

This young man appeals to the average girl, because he is learned, proper and respectable. She is certain that in every situation—school, street, home, park—she need never fear that he will as much as hint that he loves her; she knows, however, that he does, because he has never turned down a mild hint that she likes to be in his company, although he has to be maneuvered into a date.

If this young man reaches the marriageable age before experiencing a mental breakdown, he may become engaged to marry a girl. During courtship their relations are as proper and scholarly as they were before their engagement. Anything resembling love-making is likely to come from books on the subject rather than from his inner self. If he was tense when he became engaged, the tension grows as the wedding day draws nearer. Thoughts of intimate personal relations startle him, because he has no idea as to what to do.

As a rule, it is a situation of this kind that marks the beginning

of his decline. The more he thinks of what marriage entails, the more confused he becomes. Because he has never turned to anyone for advice, he cannot do so now with respect to a topic that is so intimate. Books are not available, at least not the ones to fit his case. He reads about standard practices, only to come away from the reading with confusion and fright. Sleep is fitful; he cannot keep his mind on his work for any considerable length of time; appetite is diminishing; bowels are irregular.

Slowly he begins to think that he is developing some insidious physical disorder and he is examined by the family physician who is puzzled by the appreciable loss of weight, the sleeplessness which the patient says is accompanied by sweating. The patient adds that he feels tired all over, does not feel like eating, is nervous and touchy. The doctor is too busy to inquire into the personal life of the patient, though he does ask how things are in general and the patient says they would be all right, if he were not sick. He even mentions casually that this is no time for him to be sick, because he is to be married two months hence. The physician sincerely hopes that he can participate in their happiness by curing the patient before the lucky day. Little does he realize that the odds are greatly against him. He makes every honest attempt to track down the origin of the physical complaints by employing every effort known to him. All endeavors to diagnose and to cure are futile.

A month has passed; the symptoms have grown worse; the young man has been at home for the past two weeks, sick abed. His fiancée visits him regularly, but he is too ill to exchange cordial greetings with her. He lies mute most of the time and when he does respond to her, she gets the feeling he does not want to talk. His general demeanor is one of irritability. He conveys the mood *with his body* and she can understand well, because repeated experiences with him have trained her to know that *his body conveys what is on his mind*. On her way out of the house his fiancée stops with mother in the hallway for a short talk, the general nature of which centers around the pronounced change in his behavior and the question of his sickness is lost for the moment.

Mother whispers that for the past week he has not been like him-

self at all. He was not sharp, grouchy, and disagreeable when he had pneumonia seven years ago. In fact, he was then so kind and appreciative of her solicitude. They agree that *it is an odd sickness that disturbs the mind more than it does the body* and they cannot understand it. Mother confides that his temperament has so changed that he told her several times this week to telephone his fiancée not to visit him. He sounded as if he did not want to see her, but this is just the time, says mother, when he needs his fiancée.

During the following week mother keeps pressing him to be cordial to his fiancée and, each time she raises the question, he recoils. He feels but tries not to show his intense ire and he constantly tells his mother to leave him alone. He shouts at her. That seems to crystallize what she had vaguely been sensing, that there is something on his mind that is worrying him. She only knows it, however, by the physical ways he acts, but she knows her own son: *he never did speak his mind; he postured and gestured it.*

On the basis of her new hunch, in fact the only one that has seemed like a real possibility to her, she begs him to tell her whether he has worries and what they are. The wrath mounts in him and she is afraid. Maybe he is going out of his mind. Finally the family doctor and a psychiatrist agree that the mental element is more obvious than the physical and the patient should therefore be taken to a psychiatric hospital.

In the hospital he is mute and resistive. Psychiatrists say that he is in a state of *catatonic stupor*. By *stupor* they do not mean that he is unconscious or in a delirium, for he is not. For some reason the term stupor in this type of condition means *mutism*; and resistance is called *negativism*. He has shut himself as far as is humanly possible from the whole outside. His body is flexed at all points, that is, he shows *universal flexion* and lies immobile. He has stuffed his ears with cotton; keeps the eyelids tightly closed; and the lips are so closely pressed that they are puckered. The whole is a remarkable demonstration of *the complete shutting-off of all external stimuli*. He has to be bathed, fed, clothed; and his natural functions must be taken care of by his nurse. Often these patients do not pass urine or feces until medical measures are introduced. They have to be fed a

liquid diet through a tube passed through the nose and reaching the stomach.

There is no telling how long he may stay in this stage. It may be a few weeks, a few months; perhaps not longer than several months, because this is his first attack. Still, it may persist for a year or even several more years.

A *second* manifestation, one which the patient may or may not show, represents in principle the opposite of the foregoing. Now, instead of being negativistic and totally aloof from the environment, he reacts to it in complete obedience, showing what is known as *automatic obedience*. This is the condition in which the body will maintain any position in which it is put by another. It is said that the patient shows *waxy flexibility*, known also as *cataplexy*. When, for instance, his head is turned to one side, body bent at the hips, one arm extended forward, the other placed on the hip, the patient will hold that posture for inordinately long periods. He may also *echo* the environment. When he does, he repeats *echo-fashion* everything that one says to him (*echolalia*); he strikes postures or carries out movements that he sees in others (*echopraxia*). Once a pose or movement is taken, the tendency is for it to be held or continued for perhaps hours. It may be repeated daily for months or years. This represents *identification with the environment in the highest degree, the patient losing his own identity completely*.

The ego development of this individual is so weak, his fear of people so great, that it causes him either to flee in panic, which he does by curling up within himself, by shrinking, crouching, shutting off all contacts, or by adopting an attitude of entire compliance. While he is so weakened, it is clear that he is at the mercy of any force that can operate upon him. Unfortunately he is so subjugated to the environment in the stage of automatic obedience that nothing of a constructive nature can be done with or for him; therefore, forces from the outside are ineffectual. This state of helplessness is taken advantage of, so to speak, by the forces in his unconscious, which have not lost, but have gained strength, for they are no longer held in abeyance by the conscious self.

Just as in the hebephrenic form of schizophrenia, the primitive drives now thrust themselves upon him, bringing into consciousness all the primordial psychology mentioned under hebephrenia. When these appear, his attention is drawn to them and away from the environment from which he shrank. He has a new environment, a prehistoric one that fosters in him strength, confidence, omnipotence and all that goes with those attributes.

He therefore enters a new phase known as *catatonic excitement*, which denotes activity stimulated from within himself. Because his way of reacting has always been largely through body postures, gestures, movements, the primordial drives take the form of expression to which the patient is conditioned. In the stage of catatonic excitement, therefore, one sees a variety of so-called bizarre acts, peculiar in the sense that they comprise a body language to which we are not accustomed, but which is decipherable in terms of primitive mentality. What the patient says and does tends to be repeated over and over again. Thus, the patient repeats words or sentences, verbal or written and he repeats actions. This repetition takes the name *stereotypy*. Stereotyped language is called *verbigeration*.

The course of the catatonic form of schizophrenia is variable, particularly in the early years of the illness. Recovery, complete or partial is not uncommon from a first attack. A few who recover may remain well for years, perhaps for life. But the majority have subsequent attacks, each of which lasts longer than the preceding one, until the illness becomes chronic. Some become chronic from the start.

TREATMENT

Treatment of the schizophrenic group as a whole is far more effective when instituted early in the individual's life. In that way it is not the treatment of schizophrenia as such, but of the person who may become schizophrenic. The parents of the child are usually in the most favorable position to introduce such measures as may be expected to bring about the best results. They should, however, be relatively free from distorted points of view, which can

well create double jeopardy for the shut-in child. If the parents can recognize with reasonable accuracy the tendency of the child to crawl progressively into himself, they have the advantage of slowly, *very slowly*, externalizing the child's interests, never forcing, but making the child's surroundings attractive to him, so that he may gradually, *very gradually* come to use his surroundings to his benefit and to give the environment as much as he receives from it.

Parents who are emotionally starved themselves are not qualified to bring up a child, especially a schizoid one, for the reason that they feed upon the child, and in so doing sap strength from him. Many a parent unknowingly sacrifices a child on the altar of his or her own emotions. When the parents are doubtful of their own judgment or when too certain of it, they should turn the problem over to a child psychiatrist for examination of all the conditions in the home and for advice on what to do. If this course were taken, it would undoubtedly reduce the tribulations of the family; experience shows that it might prevent the most pathetic of all mental disorders. It also might not, but it would at least give the parents the knowledge that they had honestly done all they knew to be possible. It would spare them the self-condemnation that they almost always feel, when later they must send their child to a psychiatric hospital, perhaps for life. That is an unforgettable shock in itself, made the more piteous when the oppressive thought of possible neglect on their part is superimposed. Most people will eventually accept inescapable circumstances, if they are not conscience stricken about real or probable negligence on their part. Day in and day out, psychiatrists are called upon to discuss the role of the parents in the genesis of schizophrenia and often they are hard-pressed to tell the truth, especially in those instances in which it appears that the parents have contributed heavily to the development of the illness, since the truth may be too hurtful if told too bluntly. Moreover, it must not be forgotten that also psychiatric judgment in a matter of this kind may be fallacious.

The physician in the most auspicious position to do the most good at the earliest time is the baby-specialist, the pediatrician. With ample psychiatric information on childhood he occupies a

strategic post of great importance. The parents already have confidence in him, he already has faith in them. It is a propitious conjuncture. The pediatrician does not have to do any such thing as intensive psychotherapy, as it is understood with respect to adults. Indeed, his part is comparatively simple. First and foremost is the question of correctly sizing up the situation, not by hunches, but by the facts that go to make up the family situation. Impartiality is his principal instrumentality. Then comes his judgment and finally, his advice.

There are two major methods of approach, both of which should be simultaneously employed, neither of which should be hurried. In the first place, the parents must reduce their solicitude towards the child to reasonable limits, if necessary, or to increase it, if it is too meager. There is the so-termed happy medium, recognizable when the child and its parents are happily growing together. It is not difficult to see that the emotional bonds are too strong or too weak. The wish to see is to see. There are no rules of thumb to be applied to this or that general family situation. What is prescribed should be the result of the study of the individual family. This is mentioned for the reason that *too frequently a good rule is ineffectual, because it does not fit the case at hand*. Care should be taken also to avoid following the advice of authorities on the subject too literally, unless the facts warrant such procedure, because the parent can fall into the trap of selecting only such recommendations as he or she wishes to choose. Books are not curative agencies. At best they are assistants that point the way to security.

The first requirement, therefore, for the management of the shut-in child comprises an honest, impartial attitude on the part of the parents, who must come to know themselves as individuals and as joint partners in a project. They must learn to work in reasonable harmony with themselves and with the child, always keeping in mind that what the child does and thinks is for the first many years in large part due to their training. It is only in very severe instances of introversion that their influence upon the child's life is relatively ineffective. Those cases are few. It would be more wholesome for the child, if the parents assumed that their role is

always primary. If later they have to conclude that the forces within the child are greater than theirs, they may have the satisfaction of knowing that what they did to bring about favorable results was all that they could do.

Parents should get down to the level of the infant's mind, for it is only from that level that they can see the little world about them as the infant sees it. But, to the child's mind the world is not small; it is big, overwhelming, formidable. Moreover, *it is an entirely new experience*. The average parent expects the child to see the environment as the parent sees it. The child cannot do that with any more success than the parent can, who, limited to a knowledge of simple arithmetic, is suddenly faced with trigonometry. *Children must, of necessity, be brought up slowly, starting from infancy, not from adolescence*. Only too frequently the infant is measured by standards of late childhood or adolescence. We adults too often expect the education of the *emotions* to advance by leaps and bounds, but we wait patiently for physical and intellectual growth.

Even at mature age, one does not know all the answers to his own problems of living and yet he has had considerable experience with the environment. It is not reasonable to expect the infant to know anything about it for quite a while. He has to be taught from "scratch."

For a long time the infant is prompted into action by his instincts. He reacts automatically to them, because he is not equipped to do otherwise. Parents have to give him the equipment which will enable him to guide his energies through the environment. Parents must guide the love and the aggression, possessed by the infant. They must draw out the energies of those impulses by means of the corresponding energies within themselves. Love from the parent should tie in with love from the child. Aggression from the parent should tie in with aggression from the child. In each instance the combined result should be wholesome activities conforming with the *mores* of society.

The *very early* management of these two instinctual forms of energy is greatly to be desired, if for no other reason than preparing

for the proper direction of the most disturbing manifestation of instinctual energy, namely, sexual. When an infant's love and aggression are improperly handled initially, when, for instance, they are not given satisfying outlet, the sexual impulse, powerful as it is, takes advantage of this situation and appropriates all the energy it can lay hold of. Under any circumstances its demands are great, as well as selfish. It is an error to make available to the sexual impulse more energy than the child can reasonably consume, assimilate and control. Therefore, the parent's first duty is to direct much, not all, of the child's energies into nonsexual forms of activities. There should be a wholesome interchange of love and aggression between child and parent. But sex is not to be neglected.

It is not at all impossible to familiarize the child with correct sexual information when he asks for it, when the occasion seems appropriate, or even if he is known to be reluctant. It can be done without hurt to the child or the parent. The parent who goes to extremes is likely to condition the child's mind unfavorably. When the parent clamps down violently on any information, this is as true, as it is when the parent opens up the topic in all its realism. Sexual energy can be dangerous and it, too, needs to be brought out in easy and leisurely stages.

The child honestly wants to know where he came from and in the early years he is ordinarily contented with something resembling a specific answer. What counts to the child is the *way* the parent answers, rather than the scientific truth. At a certain period in the infant's life, the cabbage fable gets good results. If the parents will remember that the child has no notion whatsoever as to how he (or she) got here, they will be freer to introduce the topic of his coming with an answer acceptable to the child at the time. The child is not asking for a discourse on the sexuality of adults; he is not even asking *how* he was born; he is trying to find out whence. The answer is simple for the average child, four or five years old, when told that he came from inside the mother. The child will ponder the answer, to be sure, but he has been given the truth which does not hurt. *It is inadvisable to give more than is asked for in these early years, unless it is in the nature of verifica-*

tion of the place from which children and animals come. The best answer to the child is the truth given in the spirit of frankness. The child recognizes immediately whether the parent is hemming and hawing; he senses revulsion on the part of the parents or an overenthusiasm to tell and show all and wonders what terrible fault he committed with a simple question.

Too often, also, the child is led to believe that there was something awfully wrong between his birth and the source of his birth. Here is the start of a child's concept of the original sin. Usually the whole matter could have been settled peacefully, if the parent had answered honestly. We adults call the child's first questions *sexual*, when in truth they are more biological than sexual; the child wants to know *where he came from, not how*.

A little later the child comes to ask *how* and then a satisfying answer lies in simple truths. All things grow from seeds, one seed from the mother, one from the father. That is why—mother explains in order to give candor to the topic—that is why daughter is like father in certain ways and like mother in other ways. If there are animals around the house they can be given as examples. *It is the spirit with which the parent talks to the child that counts every bit as much as the facts given.* The average child will be satisfied for the time being with the frankness and truth as experience has usually shown.

The parent who volunteers too much is very apt to make a mistake, for he or she gives more than he, the child, can assimilate. When your child asks you what algebra is, he (or she) gets all confused when you introduce the subject by way of equations. Say merely: "algebra is a part of mathematics, higher than arithmetic," and the child has found out what he wants.

The tot is entitled to the same honesty when he or she notices the differences in the structure of the little girl and little boy. The parent who acknowledges that there is a natural difference, just as natural as it is for the boy to wear a certain kind of clothes and the girl to wear her kind, supplies a kind of explanation that takes reasonable care of the child's curiosity. For it will always be curious, and there will always be questions. Answer them as they arise

without any display of shame, but with prudence and the spirit of helpfulness.

The parent who, under the pretense of giving the truth, the whole truth and nothing but the truth, transmits to the innocent child full lessons in sexual anatomy and physiology, is gratifying his or her own abnormality. The parent is doing as much harm to the child as he would be doing, if he violently forbade any reference to the biological urges. Who makes this topic of sexual biology so great to the child? The parent, or should we say, we adults. It is our mind that converts a child's fair and decent question into one of alleged immorality.

No one can deny the paramount meaning of sex in the lives of human beings. Nature herself places sex in a high and commanding position, often making it the issue around which the rest of our activities revolve. We adults too frequently and unwittingly magnify its power, either by trying to subjugate it or to give it free rein. In neither instance is sex reasonably well managed. Why might it not be more judicious to follow the example set by nature when she prepares the child by very slow and easy steps over a period of approximately twelve years before she energizes the reproductive zone for procreative purposes? Can we not be as helpful to the child by a like slow and easy method?

This discussion issued from the idea that *the first requirement for the successful management of the shut-in child is the education of the parents, the education of their emotions.* The second requirement is built around the child. A reasonably fair estimate of the intensity of its emotional shut-inness can be made by any parent. If not, then a well-versed physician can do so. With knowledge of the intensity of schizoidism in the child, it is possible to begin the commonly slow process of bringing the child's emotions outside of himself, attaching them first to the parents, who must realize what most parents do not want to know, namely, that *parents* are stepping stones to the child's future. A great error is committed by those parents who look upon their future as that of their child also. They do not appreciate the fact that *the child is expected to grow from them to others.* Many a mother lives the role of a

mother, sweetheart and wife to her own son. Many a father lives an equivalent role with his daughter. The son or daughter, as the case might be, has little or no opportunity to be himself or herself. If the child's inborn tendency is to remain seclusive, its fate is sealed by overpossessive parents.

The shut-in child needs to have its emotions externalized, first upon the parents and the many facilities of the home, then upon other children of like age in and out of the home; later upon teachers and schoolmates; still later upon members of either sex and so out into the world, until it acquires the position of relatively independent thought, feeling and action. This is the essence of psychiatry.

To the best of our knowledge today, prevention of abnormal shut-inness is urgent, since the medical profession has not yet been able to devise curative remedies when the symptoms have once gained a foothold. Psychiatric hospitals are invaluable, but their powers are limited. What do they do for these patients? They try to do what the parents perhaps did not do and too frequently it is already too late. We must not forget, however, that as yet certain patients cannot be helped even when surrounded with the best methods of growth, *but most schizoid patients can be benefited.*

In schizophrenia the one aim of the hospital is to draw the patient's interests away from his symptoms and towards healthy pursuits.

There are five principal professional means for trying to effect such a transition.

(1) The *psychiatrist* administers psychotherapy, that is, he tries to get the patient to see the origin and development of his symptoms. He strives to encourage the patient to see that he is using an ineffectual way of living and that he is being controlled by his inner self, not by his outer self. If the psychiatrist can free the patient's emotions from his symptoms, the hospital has immediate facilities for trying to keep the released emotions outside and attached to natural, wholesome interests.

(2) The *psychiatric nurse* participates actively in this program

of growing out and up. Her own personality plays an invaluable part in this process. To the schizoid she (or he) is a *new parent*, who tries to induce the patient to grow up in this *new home*, the hospital. She does this in a multitude of ways. The best-arranged psychiatric hospital has the facilities of a home, school, recreational center and workshop.

Nurses and (3) occupational therapists work hand in glove in all these endeavors of work, play, sociability, dances, card games, lectures, athletics, etc. The modern psychiatric hospital makes provision for the continuation of formal education by setting up classroom facilities which are staffed by (4) *teachers* assigned by the department of education. The patient is made to feel that he is a *human being*, not a case, that everyone is interested in seeing him grow up.

(5) Intimately associated with these various influences are members of the *social service* department whose main activities take place after the patient has left the hospital, though in anticipation of his leaving he has been prepared partly through social service. The social worker is the liaison person between the hospital and the new environment.

Each of the foregoing units—the physician, nurse, occupational therapist, teacher and social worker is part of a team, so to speak, whose combined endeavors are designed to free the patient's interests and energies from his symptoms, so that the interests and energies may be applied to normal, environmental activities. As a rule, one of these five units is the principal means by which the patient grows up. The personnel of the unit frequently means more to the patient than technical skills do, because he needs education of his emotions, even more than of his intelligence. The teacher, social worker, nurse, occupational therapist—any one of these—by her or his own personality may be the main influence in the patient's improvement. Moreover, there are times when another patient or other patients contribute considerably in drawing a schizophrenic patient out of his "shell."

The patient has a body as well as a mind. It is certainly necessary to continue research as energetically as possible with respect

to the anatomy and physiology of the schizophrenic subject, because the more one studies the patient, the stronger does the belief grow that, at least in schizophrenia, general physical functions often lag behind in development to about the same degree that mental functions do.

Change of Life

Formal classifications of psychiatric disorders undergo changes with the acquisition of newer and more advanced information. There was a time when the diagnosis was based upon the principal symptom that troubled the patient. This arrangement resulted in a discouragingly long list of diagnoses. Then symptoms began to be grouped under larger headings and the totality of concurrent symptoms, called a *syndrome*, led to fewer subdivisions. At the present time classification is based on a combination of symptoms and the type of personality from which the symptoms grow. That this is not always the case is clear with respect to those mental disorders that start later in life, from the age of forty-five onward. This is due, perhaps, to the fact that research has not been as extensive with this large group as it has been with the groups that have the onset of their mental disorder earlier in life.

The transition from natural personality seclusiveness to morbid seclusiveness is readily seen today, though in the past it was not known that there was any significance attached to the relationship between the two. Before the science of personality was as well developed as it is today, medical men applied what they knew best to the understanding of psychiatric disorders; that is, *they tried to explain mental deviations in terms of organic abnormality. This search proved fruitful in two main ways.* (1) It uncovered organic backgrounds that had not been formerly recognized. For example, there was a whole group of patients with mental illnesses which we now know to be due to syphilis of the brain, but which only a few decades ago were thought to be due to their ways of living. (2) Further intensive organic studies, negative as they were, proved

highly valuable because they lent positive credibility to the newly developing science of the personality.

It is a natural tendency, perhaps rooted in hope, to look upon one's special field of endeavors as more or less complete and final. We want things definite and unchanged. This wish seems to be particularly strong among those who are specialists, those who come to know more and more about less and less. The inclination to champion a cause dwells in all of us. Such an inclination has merits, but it also has pitfalls, because it narrows our horizon.

All human endeavors are in a state of flux, and psychiatry is no exception to the rule. Unless we realize that we are always moving towards new points of view, we are apt to lose, perhaps, the most important perspective we should have.

The human being is a psychosomatic entity. He has a goal in life—to *live in harmony with himself and with others*. What he accomplishes in life is a reflection of that motive. He grows into, becomes a part of, society, which, over the years, develops special groups with special functions, many of which are available to him as he passes through life. The professions, trades, diversions, entertainments, sports—each serves to foster healthy, wholesome integration.

Physicians form one group of this general plan. Their special province is to do what they can to keep the body in good running order. Psychiatrists concentrate their interests upon the human side of the person, the emotional side, while not overlooking the fact that it is the smooth coordination of all parts of the individual that makes for success in life.

With specific reference to the topic of this chapter, we know that the human being has to meet and solve to the best of his ability a series of difficulties, not the least of which is that psychophysical landmark called the *change of life, or, the climacterium*. In point of time it is more or less clearly defined in women, setting in around the age of forty-five, while less is known about its approximate onset in men. The climacterium marks the termination of fertility in women, and, presumably, of spermatogenesis in men.

A great deal is still unknown about the finer psychophysical changes that may occur at this period of life. At present physicians have only the vaguest ideas of what the climacterium means to the human being. It is a transition point, like birth and puberty, in that it is associated with a rearrangement, so to say, of the individual's anatomy and physiology, as well as of his or her psychology. It is a popular belief that the climacterium marks the onset of the period of decline, called in biology *involution*, in somewhat the same sense that puberty signalizes the beginning of maturity.

The psychiatrist recognizes the emotional significance of the climacterium, at least enough to realize that it is often a very trying period of life for many people. Experience seems to indicate that it can be a perilous phase of life for those who are inadequately prepared to meet it, from both the physical and the mental points of view.

Speaking only from the emotional standpoint, at present there seems to be sufficient evidence to warrant the opinion that *it is equally wise to prepare for the involutional span of life as it is for the span of maturity*. To date, little has been done by physicians to make the involutional period as useful and vital as it should be. In view of the rapid advances being made in the matter of prolonging life for an ever-increasing number of people, it certainly seems that the involutional period may soon become as important in its own way as are infancy, childhood, adolescence, and maturity. It might even be suggested that the terms *involution* and *climacterium* either be dropped or that their meanings for the life of the individual be better defined or brought into conformity with newer points of view. Sometimes the most productive period of a person's life follows what is now known as the peak of life. When that is so, science must set the peak or climacterium (except with reference to sexual reproduction) beyond the reproductive phase.

It was generally thought that mental disorders occurring at puberty—the coming into manhood or womanhood—were definitely connected with organic changes attendant upon the transition to maturity, though there was no evidence to support the hypothesis. Then came a wave of endocrinological research, which is

still with us and which has contributed some excellent results, but has not yet helped to improve mental disorders as such. It is good medical practice to correct a known endocrine disorder whether it be in a psychiatric or nonpsychiatric patient, but so far it is still an error to believe that the most useful glandular treatment will also benefit in a substantial way a mental disorder rooted in the personality. It helps any person to have a disease or disorder corrected, but to expect organic remedies to have equal effect upon both organic and mental structure is to close one's eyes to past and present experiences in thousands upon thousands of patients. No one would wish for that remedy more sincerely than a psychiatrist, but no one feels more keenly than he that the remedy is still not at hand.

If the general point of view expressed in this book—that the mind is the equivalent of an organ of the body—has any validity, it must perforce follow that the treatment and cure of another organ, as the heart, lungs, liver, etc., is beneficial to the mind only when the disordered organ makes its influences felt on the mind. If we assume the cause of emotional disorders to be physical in nature, then why is it that the incidence of frankly psychiatric states among those who are physically diseased is not nearly as high as it is among those who are physically sound? Is it not possible that a sound *mind* can and does resist ravages of the *body* to a very high degree? In such severe physical disorders as tuberculosis, cancer, heart disease, brain tumor, etc., the frequency of out-and-out psychiatric states is less than it is in what we today call unimpaired physical states.

Mental disorders of puberty are best recognized today as abnormalities of emotional growth and are most effectively treated from that point of view. Likely, the coming into sexual maturity is as some as yet undetermined organic relation to the mind. It is difficult to believe that psychological and organic puberty are unrelated processes, yet we must be practical with what we know, namely, that the only correlation we possess at present is one of simultaneity in time, not sequence of cause and effect. We can cite any number of instances in which psychological sexual maturity

appears long before or long after organic sexual maturity. The solution of this baffling enigma is one of the heritages we leave to future medical scientists.

In respect to simultaneous psychological disorders—such as *involutional melancholia* (a process opposite to evolutionary)—the passing of organic sexual maturity seems to be just as important to man as is its coming, even if not so significant numerically, for so far as admissions to psychiatric hospitals are concerned, there is approximately *one patient with involutional melancholia to ten with schizophrenia*. Just to what this difference may be due we do not know, but if a person has reached the change of life period without having been stricken by a mental disorder, it is not improbable that the person will go through the involutional period without essential mental deviation.

To size up the possible relationship between organic and mental factors of the *involutional* period is no easier than it is of the adolescent period. Whether it be the one or the other period of life that the individual is about to face or is facing, we feel that *the strength of the personality* is an important determining factor in the way by which the issues are met. When the schizoid individual meets the impact of *oncoming* maturity, he usually becomes more schizoid, if not schizophrenic. The cycloid person may become more cycloid, the hysterical more hysterical, the obsessive more obsessive. The mental equipment that one has at the time of the change seems to bear decisive influence on his adjustment to the change.

The same general idea prevails as regards the forms of adaptation to the *passing* of organic sexual maturity. It does not seem to be merely coincidental that those who fall mentally ill at this time of life are the very ones who barely escaped a mental disorder at puberty and subsequently. They were borderline cases, so to speak, before they arrived at the period of change of life. Many of them avoided a mental breakdown by seeking a protected environment and by learning how to get along with a minimum of nervousness. Some of these people escape severer manifestations of mental deviation, perhaps, by living with their parents rather than leaving them

in favor of a career of independence. Others may leave their home, but go to new ones in which, however, they still play the role of son or daughter. Still others may be children to their employers, from whom they expect and often get advice and care in matters of living. Many employers must also be fathers and/or mothers. Still again there are those people who marry, perhaps raise a family, but basically they are "home bodies." Many of the latter subordinate themselves to their children before the children are out of childhood. These and others of a similar nature are so-called borderline "cases." Their margin of emotional safety is narrow and is maintained only when the environment can be made to meet their immaturity.

There is no one group of symptoms characteristic of what is called involutional melancholia (involution here means the change of life from the reproductive to nonreproductive stage), but *almost all the mental troubles have an element of melancholia*. Without them, they take the diagnostic designation from the most common symptom.

(1) When the individual's personality organization is of the shut-in, schizoid type, a mental disorder (if there is one) at this time of life, will resemble, often very closely, one of the four subdivisions of schizophrenia: the simple, paranoid, catatonic or hebephrenic form, usually mixed with sadness of great or small intensity.

(2) When involutional melancholia comes upon one who previously was a borderline manic-depressive patient, that is, one liable to manic-depressive psychosis, it will most likely resemble the depression of that mental disorder. Commonly it is a *depression with great agitation*; less frequently it is a retarded depression; and still less frequent is the manic phase of manic-depressive psychosis. Whatever its distinctive appearance may be, usually the course of the disorder is protracted, lasting at least several years, though shorter runs occur. It is this form of involutional melancholia in which favorable responses to electroshock treatment are frequently encountered.

The agitated depression that these manic-depressive-like patients

show is extremely severe as a rule. Often they are in a terrible state of anxiety, because they believe themselves responsible for the death or maiming or illness of their loved ones. It is not uncommon to see a mother, who for years had sacrificed herself to incessant solicitude for her husband and children, wringing her hands in violent grief, because she believes she and they are about to suffer the torments of hell. This formerly kind wife and mother, who never did a wrong act, pleads earnestly with the physician not to send her to the torture chamber, where she expects to die slowly of starvation and to be tormented physically by the most horrible instruments. She tries to commit suicide so as not to have to face eternal horror. She knows, she says, why they are going to be so mercilessly cruel to her. It is because she has brought illness on her children and husband, as a result of which they, too, are slowly dying. She explains that for months prior to her coming to the hospital she could not prepare meals for them; as a consequence of this neglect they are so weakened that they will soon die. "But they are already dead!" she cries. She read in this morning's newspaper that a child of twelve was killed by a truck. The name given in the newspaper was not that of her daughter; the newspapers hid the correct name from her. The patient wails, screams, tears her hair, grasps violently at her body. She asserts that she weakened her daughter so greatly, that the daughter's mind was blank from starvation and she did not know she was walking directly in the path of the truck. Two hours later, when daughter visits her mother, the latter looks astounded and horrified at the girl, who, she maintains, is a substitute for the daughter. Daughter begins to recall what she believes will be vivid memories to the mother as proof of her existence, but mother sobs with unheeding vehemence, sometimes acknowledging that daughter is correct, but shaking violently, because she has caused her death.

Someone shuts a door. The sound is magnified in the patient's ears and interpreted as a pistol shot; her husband has just been killed. It is all due to her, because he would not be at the hospital to fall the innocent victim of an assassin if she were not there. She must kill herself for making his death possible. When he visits

her, his presence seems to be taken as an intellectual fact that does not in any way counteract her feelings that she indirectly killed him. The impulse to believe virtually blinds her to his physical presence.

Before these patients get to a psychiatric hospital, they cause untold grief to the members of their family as well as to themselves. For months and months, they follow each member of the household around the house, crying: "I love you, I love you; but look at what I'm doing to you; murdering you; yes, I am; really murdering you. You look so sick. But, I can't cook for you. You're getting pneumonia; I know it; I heard you cough; I couldn't get up during the night to close your window and put an extra covering on your bed. You're dying, dying because of me."

This goes on with all those to whom she was endeared. If it is the husband, he vainly tries to assure her that everybody is all right; the girls are really good at preparing meals; they make appetizing and substantial dishes and they are clean and economical around the kitchen. The patient nods in deference to his honesty, but in commiseration of his blind innocence. She is sure he does not and cannot see what is going on, for he never paid much attention to household affairs.

She scans him carefully, endlessly, as he prepares to leave the house to go to work. Doesn't he feel sick? No? But, he is. "Please, please, don't go out, you'll never return alive!"

It is one of the most heart-rending scenes in any household. Reality has been tried a thousand times, all to no avail. She is sure his death is imminent. Kindliness from him is totally ineffectual. He tries to shut his eyes to her terrifying anxiety; no changes are seen in her. Then he turns to firmness, which he had never had to use with her, but he tries it with the result that she begs for more of it; she insists it is what she should have, even worse; he should beat her unmercifully for all her terrible sins. He is now completely at sea, because his assumed meanness loosened a flood of self-accusation.

With ever-increasing trepidation she finally lets him leave the house. She is panicky when she dwells on his agonizing pains; she

imagines he slips under the bus and is crushed. She pictures him in the bus, if he escaped death, but the bus skids, overturns and he is killed. If he survives thus far, the elevator cable snapped, plunging him to death in the pit, as he was riding up to his office.

Ordinarily it takes him forty minutes to get to work. He should be there by now; she checks on the time; the clock indicates he has been gone twenty-five minutes, but to her it is forty-five. She telephones his office: no, he has not come in yet; yes, he sometimes gets in about this time. Her anxiety proves to her that he is dead. After two more unsuccessful attempts to reach him by telephone, she finally does reach him. The conversation is strained. She falters, does not know what to say or think; somebody is answering in his place. For several minutes she is asking whether this is really her husband; how can it be? He does not know how to answer that. After some soothing words that never soothe, he quietly replaces the receiver. If he does not go home immediately, he is bewildered all day long. She calls him by telephone about every hour; not much has been said except his calm repetition that he is at work in his usual place. "You mean in your own office?" "Yes." "You're not in a hospital?" "No." "I just heard some bells; it's an ambulance and you don't want me to know. I knew it; I did it; I did it."

He is greatly alarmed, because he knows she believes she has committed a crime for which she must kill herself. Maybe he rushes home to find her dead or in the act of suicide. If she is alive, he sits down to reason with her that she is very sick and should go to a hospital. For the past several weeks the family physician has been advising her to do that.

Go to a mental hospital? She shudders at the thought. Then she would be crazy; then she would never know what happened to her loved ones. The play upon the family's sympathy is heart-breaking. She would rather die than leave them. Each one looks pathetically at the other. For weeks there have been no decisions, only havoc. The doctor calls. In conference with the husband and the older son—two other children are instructed to stand close by their mother; they know why; she might commit suicide—the doctor says he will call an ambulance to have her taken to a

psychiatric hospital. They have been trying endlessly to get her to go voluntarily; she begged them not to send her away. They explained that she could enter the hospital on her own volition by simply indicating in writing that she wished to enter for purposes of being treated for her sickness. She was told that she could leave at will, but, after she had made application for her discharge, she could under no condition be kept on a voluntary basis in the hospital beyond the number of days specified on the admission form she signed when she entered. If, for example, she applied for discharge three days after admission, she could not legally be kept in the hospital on the voluntary form longer than 10, 20, 30 days more, or whatever number of days might be the law in the given community.

Suppose they do not want her to leave? They might not, for they feel that the risk of suicide is too great. They may then take steps to have her certified by court order, under which circumstance she remains in the hospital at the discretion of the hospital staff.

Ordinarily the patient who is as ill as has been described will not make a move for treatment. Therefore, she should be regarded as mentally irresponsible and committed or certified to the hospital. There are many patients, however, whose mental turmoil is not so severe as that just related. They go to the hospital at their own request.

Electroshock treatment is in vogue at the moment, because it appears to shorten the course of the illness. Since this form of treatment is still in the nature of research, it is not possible to gauge its efficacy with any feeling of certainty. Almost all authorities agree that other hospital facilities—psychotherapy, nursing, occupational therapy, social therapy—should be used intensively with, but particularly after, the close of electroshock treatment.

The best form of treatment, however, is prevention. It is not at all difficult for the members of the family to know that the wife (or husband, as the case might be) whose activities are narrowed to her own small household (or the husband to his job and little else), who cleans, scrubs, dusts and prepares the meals day in and day out, who is ill-at-ease with company, unless they are relatives

who have been visiting her for years, who has no recreations or hobbies, *may* go through the menopause with little more than physical discomforts, but it is not a chance worth taking, especially since preventive measures are so simple to try. Again, the keynote is a widening of her interests, a process that can be extended over a period of several years in order to gain desired results.

After all, does it not seem worth the effort to prevent such a direful state, which has all the appearances of an unconscious violent rebellion against the narrowness of her life? It looks as if she can no longer stand her caged-in existence; she can no longer be a captive in the hands of her husband and family. She casts her irons off with a violence and a fury that bring catastrophe upon all.

Endocrine substances help the endocrine disorder, but they are not known to affect the psychology of the patient in any substantial way. Indeed, at the moment, the medical field is essentially helpless in bringing about favorable results in the most pronounced cases. The milder the patient's condition is, the better is the opportunity to put *socializing* agencies at her disposal, though it is still a task of no mean proportion to make a social being out of one who for some forty odd years has been an emotional recluse.

(3) If the patient pressing onward towards the menopausal period of life has been a mild psychoneurotic most of her life, that tendency may be acutely intensified at the change of life. Those with a character *neurosis* are very apt to have an increase of their peculiar character traits during this period. The fussy become more fussy; the thrifty save everything, including the most useless things; the meticulous are more than ever demanding for accuracy; the unkempt now do not bathe or change their clothes; the food faddist does not eat, because the food is never right. Fears, obsessions, compulsions, conversion phenomena may become greatly exaggerated during the menopause.

Usually a mental state set free by the menopause begins to show itself, even in a very mild form, when the menses first begin to change, though the abnormal mental condition may appear at any time while the menses are disappearing. It may come upon a patient after menstruation has ceased completely.

In men, involutional melancholia ordinarily begins some years later, perhaps five to ten or fifteen years later than in women. For this reason the mental state may extend into and be influenced by such conditions as hardening of the arteries or a general reduction in vitality or premature aging. Any one of these conditions may cause the melancholia, or whatever mental state may be present, to be extended, perhaps, through the rest of the man's life.

Epilepsy

Back in the time of Hippocrates (460–377 B.C.) and for centuries thereafter epilepsy (from Greek: a grasping, a seizure) was recognized as having a strong psychological element connected with it. It was thought that the seizure or fit was the result of some supernatural power that entered the body of the patient, that there was something sacred about the disease; indeed, it was called the “sacred disease.” Over the succeeding centuries it took the name of various saints, Saint Dymphna’s disease, Saint John’s evil, Saint Mathurin’s disease, Saint Valentine’s disease, St. Vitus’s dance. The convulsive seizure itself was regarded as a *result* of some influences, not as a cause. Essentially the same opinion prevails today, namely, that the fit is a symptom to be classed with other symptoms such as headache, dizziness, vomiting, faintness, etc. In other words, *epilepsy is not a disease, but is one of the phenomena of abnormality.*

Today medical authorities prefer the general caption *the epilepsies* in order to convey the impression that a convulsive seizure may be caused by one or more of several underlying conditions. From this point of view the epilepsies are subdivided into two large groups: a) *symptomatic epilepsy* and b) *idiopathic epilepsy*.

a) In the first group, *the convulsive seizure is a symptom of a recognizable organic cause*, such as alcohol, diabetes, kidney trouble, disorders associated with pregnancy or with endocrine disease; it may be due to a brain disorder which is secondary to disease of the heart and blood-vessels; or to brain syphilis, tumor, injury, faulty brain development, etc.

b) *However, in about nine out of ten epileptic cases there is no tangible organic cause.* These are cases of *idiopathic* (or *true*,

genuine, essential) *epilepsy*, where idiopathic denotes a *primary abnormality, not secondary* to any other cause. This manner of classifying epilepsy is confusing; if epilepsy is a symptom, it must be a symptom of something, even if that something cannot be seen by the eye. Presumably the majority of observers want to say that a convulsive seizure can be caused by the emotions, but they do not say it in so many words. They point out that the seizure may be replaced by a psychic state, such as furor, or an aimless running around, or a flight from reality, and they stress that the energy which would have started a convulsion is diverted to the mind. This is coming very close to accepting an emotional origin of epilepsy. However, we cannot that easily dispose of the whole problem and the better judgment seems to await further research. That in many epileptic patients the personality component stands out more prominently than any known physical one is a fact which will abide or go by the board when more substantial information has been gathered.

The role of heredity in idiopathic epilepsy—and from here on every reference made will be to this type only—*has always been regarded as important*, but the extent of its importance has been variously estimated by different investigators and even by the same at different times. Citations from the literature conceding heredity's role can be matched with those denying it, though there is a more or less general consensus that the predisposition to epilepsy seems to come from the individual himself rather than from his ancestry.

Epilepsy may manifest itself in one or several various ways. If we proceed from the mildest to the severest forms, we first refer to what is called the *epileptic character*. True, the existence of such a character has been questioned by many; but before epilepsy proper has set in or sometime after it has started, not a few of these individuals show an aggregation of personality traits that makes one wonder whether there is not a relationship between their personality and its epileptic manifestations. May not *epileptoidism* be a forerunner to epilepsy in somewhat the same sense that *schizoidism* is to schizophrenia, *cycloidism* to manic-depressive psychosis, *hysteroidism* to hysteria?

That an epileptic individual is poorly integrated with life is a common observation. Some would say that he is poorly adapted because of his epilepsy, while others maintain that he is epileptic because of his poorly adaptable personality. It is not unlikely that some physiological abnormality, perhaps in the form of distorted energy, may give rise to both. But the best we can do at the moment is to state the observable facts.

1. One of them is that *many epileptic patients have a peculiar set of character traits*, described as bipolar, *ambivalent*, bilateral, paradoxical, each of these terms conveying the idea that opposite feelings co-exist in the individual almost simultaneously. But, a feature of equal importance is the *intensity* with which the feelings are expressed and the dominance of the *egocentricity* connected with them. The organization of the character traits and emotions is very similar to that of an infant. The epileptic individual does not essentially outgrow his infantilism. Not infrequently the severer cases go into a state that closely resembles the advanced stage of hebephrenia.

The epileptic individual, who need not be epileptic in the sense of having convulsions, may love with the greatest of ardor, so intensely, indeed, that the love seems to be almost exclusively for its own sake. But, when he loves he loves and he does not feel any other emotion. The next day, however, he hates, perhaps the same person, with the same extravagance that he loved the day before. The hate may mount to fury, to confusion, to lapse of memory for what he does or says at the peak of the hatred. This loss of memory lasts from a few seconds to many minutes, during which time he seems to carry out purposeful acts. It is a sort of fainting without loss of purposiveness.

He is at one time a bountiful philanthropist, giving away all his possessions with the most servile solicitude for the donee. The consideration that he shows to the other person is beyond all reason. But, the next day he demands all of it back with the implication that interest is due on it.

One day he benches himself from the baseball team telling each individual member of the team that the game would be ruined by

him, because they are all so superior to him. But as the innings go on and the opposition is gaining a very long lead, at his own request he heroically enters the game to wipe out the lead. Now he appraises himself highly. The shift from feelings of inferiority to those of superiority is pronounced. But the individual is so exclusively preoccupied that he does not recognize the amplitude of the change in his feelings. When a teammate joshes him about it he soberly defends his reasons for both acts.

At times he is excessively meticulous about his work. If in writing a letter he misspells a word at the bottom of the page, he re-writes the entire page. But when his interest lags, he lets many mistakes stay in without correcting them. From intense alertness to details to complete carelessness is not at all an uncommon leap for him.

He is never a middle-of-the-roader. When he is obsequious to anyone he is completely lost in fawning, often embarrassing him to a marked degree. He almost kneels in his subjugation and his judgment in so doing is out of all proportion to the amenities normal to the situation. But, the one to whom he pays such obeisance knows the individual so well that he expects at any moment to see a sharp change from deferential to abusive deportment. And, usually he is not wrong.

In his religious activities he is just as variable. His fanaticism may extend over a few years to a variety of denominations, often depending upon the possibility of gaining some office of distinction in a particular church. This pious person may be violating each of the tenets of the decalogue while so devoted to religion.

This so-termed two-faced organization of his personality may or may not be as pronounced in every detail as has just been delineated, yet when present it is very striking. The patient may go through life this way, never showing any of the abnormalities that can definitely be called "epileptic." He is recognized by those close to him as childish and dramatic, being the kind of person who writes ardent, heroic love letters in red ink, who is forever seeking contacts with people of importance, because he figures that they may be useful to him some day.

Generally he is unhappy wherever he is and at whatever he is

doing. He is a psychological nomad, who loves to travel for the sake of being somewhere else. He builds up a great future for himself and then starts towards the past. He places undue importance upon the family-tree, often losing himself entirely in daydreams about his ancestors, and frequently tries to impress his importance upon others by lengthy and exaggerated accounts about his forefathers.

Above all, he is extremely tense, though he swaggers with the bravado of relaxation. He is forever trying to study the reaction of others upon him and his upon them, wondering how much, if any, of the dual personality they detect in him. Though he may be well-educated, he lives mainly by his wits, because he lacks the capacity for sustained application to the responsibilities of the work-a-day career. Brilliant for a moment, he may be dull for an hour.

This dullness worries him greatly and he tries to conceal it from others. It is usually ushered in by mild confusion in thoughts; he attempts to organize his thoughts under relevant and coherent topics, but fails in the attempt. A hundred different ideas strike him at the same time, producing a type of perplexity that amounts to vacuity, to mental blankness. He is afraid he is going crazy, shakes his head briskly, strikes it with his hands in an effort to wake up. Finally, on gaining some measure of control he feels he must have been in a daze, because he does not know what has taken place in the last few minutes. What was he doing before this attack came on? He is indescribably anxious about something. The whole episode is likened by him to the effects of a nightmare. It is in truth a daymare medically known as a *petit mal* attack of epilepsy.

2. Some patients have these "little attacks" as the only strictly morbid manifestation of their epileptic personality. In the early months or years of their illness, they may average a few attacks a week or month; or the frequency may be many in one day with perhaps an interval of freedom from them for a week or two. As the years go by, they may increase greatly in number. When they do, there ordinarily are changes in the personality partly due to the uncontrollable emotions, partly to a peculiar form of *intellectual impairment*.

It often seems that the intellectual changes are secondary to the

emotional, because there is a *selectivity* about the things that are forgotten. Such a person may forget only the names of people who have been important to him, while remembering acutely a host of other proper names. He can recall with remarkable accuracy the full details of a recent conference he had with five people, but he has absolutely no recollection of what the chairman of the conference said; indeed, while he feels that the chairman must have been there, he cannot picture him at all. Another patient has been trying for weeks to recall his mother as she was during his childhood. He has a photographic memory—*eidetic imagery* it is called. He can see the furniture in each room, give its exact location, recite hundreds of details regarding movements of his family about the house, just as if it were all taking place right now before his eyes, but he cannot picture his mother at all, though he knows that she was a central figure in the house. Obviously his mind has blotted out her alone. It is a kind of amnesia, an *insular or circumscribed amnesia*, occasioned by the emotions. He can recall her with unusual clarity from the time that he was sixteen years old but not before that.

He shows what has been called *epileptic dementia*, a kind of emotional rather than organic loss of memory. In his particular instance—he is suffering only from *petit mal* attacks—the “dementia” is usually not pronounced, in fact, it is often not known or suspected by those close to him. At worst he may be regarded by his friends as “a sort of peculiar fellow, eccentric,” whose mind seems to wander at times. His friends say he is different, because he may not worry about important things, but he very often frets so thoroughly about some triviality that he works himself up into complete absence of mind. For days now he has had to prepare a pressing survey to present to the board of trustees tomorrow, but the tracking down of a small shipment which failed to reach a customer has so completely engrossed him that he has not yet begun the board’s pressing and significant assignment.

Generally the patient does not know when a *petit mal* attack is coming on, though he knows that when he is brooding he is apt to have several episodes. They vary in duration from about ten or

fifteen seconds up to several minutes, during which time he may or may not continue with the activities that he was performing when the attack started.

Some patients engage in "baby talk" during an attack and when it is over they maintain they feel like an infant. This does not seem to be a mere coincidence, because, among epileptic patients in general, it is not uncommon to witness the psychology of infancy connected with an attack. *Some authorities hold that many epileptic manifestations represent a sudden regression to the infantile level.* While coming out of an attack, one patient frequently thought that he was in his crib and mother was smiling at him. Another would often make sucking movements with his lips, in the belief that mother was nursing him.

3. Some of these patients experience a mounting tension that rises and rises until it seems to them that it must finally spend itself in some kind of violence; what form the violence may take they do not know; they have the feeling of blind, aimless rage. To prevent the rage's explosion many of them go through certain acts. One patient may wear off the tension by running about energetically. This aimless running around is called *aura cursoria*. A young man, getting the tension while out in the street, would suddenly start running, modifying the impulse to flee precipitously in order to give some slight justification for the sudden spurt. When in his own room he would run around and around, and at the onset of a definite feeling rising from within, he would duck under the bed clothes and curl himself up as small as possible, believing he was getting smaller and smaller until he was finally disappearing. Just when he thought he was about to disappear completely, he would become panicky and try to concentrate on real things. Within a few minutes he would be out of bed, reading, reading, reading in order to keep himself in touch with reality.

4. Another peculiar state, usually identified with epilepsy is known as a *fugue*, meaning a flight. A patient, married and having a family, had shown the ambivalent character traits of the epileptic since he came into puberty. The responsibilities of married life preyed on his mind for several years. Try as he would, he could not

improve his economic status. If he had only delayed marriage until he had saved a sufficient sum of money; *if only he had not married!* The thought kept growing and growing upon him. One morning he left the house to go to work. That was the last seen of him for eleven months. At the end of that period he was accidentally located on a farm some eighty miles away from his home. When approached by a friend who knew him well he did not recognize the friend, for he was completely amnesic as to the entire period of his married life.

When later his memory of his marital life was restored, he had only vague islands of memory for his amnesic period. How he had traveled the eighty miles was never found out. All they learned was that he had approached a farmer, asked for and received a job as the farmer's helper. At all times the patient appeared as a genial, affable man, honest and industrious. The farmer said that the patient showed a temper at times, but was tractable, and seemed happy "in his way" most of the time. The farmer was none too observing, yet he knew that the patient had never said anything about a wife or children. The patient seemed contented to stay on the farm, going to town only on a few occasions, when he needed clothes.

A young man grew tired of what he called his hum-drum way of living. He was a student, excelling in scholarship, but had no essential extracurricular activities. He grew petulant under the steady grind of studying, envied the young men in school who had varied interests and was particularly lonesome around "junior prom" time, when all were busy with the approaching social event. He went as a spectator; it "ate deeply" into him, as he expressed it, that he was not a participant. The next day he worried so much about his plight that he could not attend classes. He left the fraternity house at about seven o'clock in the evening of the day following the "prom." The next that he or anybody else knew anything about him was some seventy-eight hours later, when he suddenly "awoke" to find himself riding in a taxicab in a city several hundred miles away from his school town.

He was astonished to find himself in a taxicab and for some time he said nothing to the driver, for he wanted to look around to see

whether he could identify the streets or buildings. They looked strange to him; they *were* strange. He learned the name of the city from the driver, who also informed him that he had picked him up as a fare at a certain dance pavilion and was instructed by the patient to take him to his hotel—name so and so. He was driven there and immediately began to inquire about himself, learning the usual number of details that can be gleaned from the desk clerk, bell-boy, floor-attendant, maids and waiters. All agreed that to them he was just another guest, conducted himself with decorum, was always neat and clean; in no way did they think that he was peculiar. The seventy-eight hours of amnesia were never brought back to his memory and even a hypnotist's effort proved of no avail in restoring the lost hours to his memory.

5. A still more remarkable epileptic state that is a "flight" in a way, but is probably better described technically as a *twilight state*, occurred in a man who on several occasions informed the psychiatrist in the hospital that he did not want to be disturbed for the next two days. The patient would then undress, go to bed, lying there so completely immobile as to resemble a corpse. Suddenly he would arise and in his usual manner wash, comb his hair, eat, take care of other personal functions, then return to his immobility. He could never tell what, if anything, passed in his mind during such behavior.

The psychiatrist grew curious. During one of these twilight states, the psychiatrist brought a small group of graduate physicians to the patient's bedside. All agreed that he looked dead-like. Then the psychiatrist spoke to the patient, asking only that he reply so that they might know that he was all right. After the question had been put to him about a dozen times, he suddenly sat up in bed and named each physician present: they had been doing graduate work on the ward for some three weeks and he had had the opportunity to find out their names.

He was questioned further. Dramatizing each thought he spoke about, he claimed he was God, that he was then on the throne of God and in the process of purging the world of all sin and disease. He orated with vehemence and expressed pity for the psychiatrist who

asked him whether he was not Mr. Smith, a patient in the hospital. He replied that it was a hospital as the physicians saw it, but they had only mortal and therefore spurious eyes. He had the authentic ones. He beseeched all in the group to come unto him.

Here was a mental state in which there was co-existence of the actual reality surrounding him and of the delusion that he was God in Heaven. This type of mental activity is not uncommon in schizophrenic patients, but they acquire it over a much longer period of preparation. There is a pathetic note to the epileptic patient in that frequently he believes that through his symptoms he is curing epilepsy.

Epileptic patients who have *fugues or twilight states* are said to have *epileptic equivalents*, meaning that the fugue or twilight state takes the place of a *grand mal* attack. Equivalent states are also called *psychic epilepsy* or *psycholepsy* to distinguish them from epilepsy that manifests itself mainly in the form of convulsions.

An epileptic patient may have disorders in the sense organs. (a) Peculiarities of taste, known as *gustatory seizures* are not uncommon. (b) Nor is tingling of the hands and feet uncommon; usually it is only on one side of the body. (c) Sometimes the epileptic patient is troubled by a visual "attack," during which he sees flashes of light or is entranced by the hallucination of exquisite colors. (d) The nose may be involved, when the patient has spells of smelling peculiar odors; he is then said to have *uncinate fits*, that is, fits relating to that part of the brain having to do with the sense of smell. (e) There may also be fits in which buzzing noises are heard.

The epileptic individual may also suffer from complaints as regards the internal organs. Gastro-intestinal complaints are common; the heart and lungs are less frequently involved. More frequently, perhaps, is a set of signs and symptoms associated with the involuntary nervous system, including rapid heart beat, shortness of breath, flushing of the face, profuse perspiration, increased salivation, widened pupils, headache, higher blood pressure, and mental confusion.

6. Many authorities believe that *somnambulism* is an epileptic

manifestation, or, at least, that it is not uncommon in epilepsy. A woman of thirty had had somnambulistic attacks since the age of twenty-four. She would get up during the night, go to the kitchen, open the window wide, return to bed. The next morning she had no recollection at all of having done so. Because she was alarmed lest in one of her night-walks she might fall or jump from the window, she took elaborate measures designed to awaken herself while walking. First she locked the window securely. The next morning it was wide open. Then she locked the window and placed two chairs across the entrance to the kitchen. In the morning the chairs were back in their usual place, the window wide open. She kept adding barriers until the path from her bedroom to the kitchen looked like the result of a youngster's prank. She tied her ankles to the bed, placed buckets of water at three-foot intervals, connecting them with rope tied in five or six tight knots, chairs were tipped here and there at angles which assured their falling when touched gently or brushed against, a dozen broom handles were placed at strategic locations on the floor to make her fall; two of them held up one edge of a carpet producing a tent-like arrangement. The next morning she found everything neat and clean, with all the barriers removed and put away carefully; and the window wide open.

In the beginning, though alarmed, she accepted the challenge in the spirit of a game, but when she found out that she must have worked some nights for at least two hours—once she locked two pails of water with a padlock and had her father hide the key somewhere in her room; everything was neatly back in place the next morning—when the game reached such a pass, she sought psychiatric advice.

She was a fine-looking woman, well-mannered, tastefully dressed. She held a responsible secretarial position with a man who was known to his associates as extremely difficult to get along with. The office employees could never understand why she seemed to be so happy in her work and, moreover, how she had worked for her employer for almost seven years. Close investigation never revealed anything but ethical conduct. They had to conclude the obvious

truth—that his sadism found full swing in her masochism. She was fond of being humiliated and he produced just about the right quantity in the right form for her.

The only man that meant anything to her was her father. Mother had died when the patient was eight years old, and the little daughter was adoringly described by father as the little mother. They were exceedingly fond of each other and were always in each other's company. This form of relationship was as strong to both, when she was thirty years old, as it had always been previously. She was cordial to other men, but that was all.

At about the age of twenty-five she began to spend some time with girls of her age, but was always politely critical of them. They knew that on any issue she was sure to take a stand exactly opposite to theirs. Often they asked her frankly and cordially why she was always so "contrary," so antagonistic. She could be remarkably considerate and discreet with them at times, but ordinarily she was *with* but not of them. She fell in with this little group of women, because they provided an easy outlet for her resentfulness against women. Indeed, beneath it all, she hated herself for the manner of her living, but instead of berating herself and changing her ways she "took it out" on others.

A vivid Electra complex was uncovered through psychoanalysis. It was not unlike the father-daughter combination seen in other types of psychiatric disorders. The difference in her case was that the Electra complex appeared in an epileptic personality, in one whose morbidity manifested itself in somnambulism.

A multitude of data elicited made it clear that the factors involved in the somnambulism were connected with her struggle to grow away from such relationship with her father. Yet, the effect of the somnambulism was to bring her into still closer relations with him, because he became an actual, intimate part of her night activities. He often watched her removing all the obstacles and cleaning up the place and he possessed the proof, for which she did not ask, that she did it all.

The main theme in her life, as she so frequently proved during psychoanalysis, was what she called the shameless love she had for

her father and he for her. Ever since he first referred to her as "his little mother," she strove valiantly to be the best little mother, better than any. She used to ask her father how she compared with her mother and he always kindly intimated that daughter was ahead of mother.

Throughout her adolescence and into maturity, father and daughter were inseparable pals. They shared the same diversions, went on vacations together, discoursed at length on affairs of the day. And she never relinquished the joys of keeping house for him. According to both father's and daughter's accounts, she grew from "the best little mother" to "the best big mother." To be the mother of her father's house was, in her own words, "the highest achievement possible."

But, what has all that got to do with somnambulism? During treatment periods it was brought out that the earliest acts of somnambulism were not primarily concerned with the kitchen window. Without any recollection of ever having done so, she used to get out of bed, prepare a light repast for her father and herself, clean and put away the dishes, and return to bed. Was it memory only on her part to recall that, in her childhood, long after she was put to bed and asleep, her parents had a snack to eat? To her it was more than memory—it was something she *yearned* to do.

So often we adults listen to such stories with the judgment of our grown-up selves, without realizing *what the story means emotionally to the relator*. There was a simple memory—to share a late evening meal with father—but to her it was full of meaning. For years it was something for which she had longed. To her childish mind the midnight snack was something very special, very personal between mother and father, done while daughter was asleep.

What did she do in her somnambulism? She prepared a *midnight snack for father and herself*, as mother used to do for father. Moreover, the daughter, as an adult, did these things while "asleep." In her somnambulism she never went to any other room but the kitchen.

But, why was she afraid she might jump or fall from the win-

dow? The answer to that question was brought out clearly by her, when she said, on more than one occasion, that "any girl who marries her father deserves that kind of an ending."

Under psychotherapy the somnambulism disappeared and the patient became interested in a few major forms of diversion, each of which helped her to grow up gradually. She has not had any formal treatment now for four years, but she visits the psychiatrist several times a year for a review of her activities and for any other recommendations that he might think in order. Both she and her father have often inquired about the advisability of her marrying, but it has been shown to them that, though free from symptoms, she has not yet acquired the equilibrium that might give reasonable assurance of good adjustment to married life.

7. The convulsive manifestations of epilepsy take the name *grand mal* ("great malady") epilepsy. While there are variations in the course and nature of the symptoms about to be described, the following is the usual sequence of events.

Prior to an attack, the patient appears moody, morose, and irritable, perhaps for days; he cannot apply himself to his daily tasks as efficiently as is customary with him. Some patients do not show such *character changes*, but generally they develop some kind of warning of an approaching attack. It may be a general feeling of sickness, or stomach complaints or constipation or increased heart-beat or any other physical disturbance. Whatever form these take they are called the *aura*.

The *grand mal* attack proper is ordinarily ushered in with a piercing cry (called the *initial cry*), promptly followed by loss of consciousness and falling. All the muscles then go into a state of great rigidity, called *tonic spasm*. Respiration is considerably diminished, if not arrested, for moments, by the sudden contraction of the muscles of breathing and of the muscles that close the glottis. Circulation is impeded, producing blueness of the skin (*cyanosis*). This *tonic stage* lasts from about thirty seconds to a minute and is followed by the convulsive or *clonic state*.

Sometimes the convulsion is first noticed in one hand; then it spreads to the arm, neck, face, torso and lower extremity. It may

remain on one side or spread to the other side. The jerking of the jaw muscles may cause the tongue to be bitten; saliva may be whipped into a froth. There may be loss of control of the urinary bladder and rectum. Usually there are changes in both the superficial and the deep reflexes as well as alterations in the functioning of the involuntary nervous system. *The clonic stage lasts about three or four minutes and is commonly followed by coma.*

The stage of *coma* usually lasts an hour or two, after which there is gradual restoration to the waking state, in the early part of which one may at times observe *post-epileptic automatism*, that is, the performance of acts without knowledge on the patient's part. When he becomes clear-minded he is usually affable and pleasant, having lost the moodiness or irritability or worrisomeness which he had before the attack had started.

The frequency of *grand mal* attacks varies considerably in the same patient and among different patients. In some it has a striking regularity, say, once a month and at about even intervals. In others it is very irregular. In still others the attacks may occur one directly after another, producing what is called *status epilepticus*, ordinarily culminating in death.

Some patients have attacks only during the night (*nocturnal epilepsy*) and would not know of an attack, if it were not described by another person, though they suspect that something was wrong during the night, because the bed clothes are rumpled and torn and there is urine and feces in the bed. Perhaps, too, they awaken feeling muscular soreness all over and the tongue may have been bitten.

Attention has frequently been called by authorities to the presence of infantile, primitive impulses that are so often shown by the patient in connection with the *grand mal* and often with other forms of epilepsy. As the patient is recovering from an attack, he may act and feel like a helpless infant. Not infrequently he says that he feels as if he were being reborn.

Patients who have a series of attacks during years commonly show what is called *epileptic dementia*, including a regression of personality to the infantile or phylogenetic level of living and intellectual impairment that seems to share organic and emotional

aspects. If the physician had not the patient's history of epilepsy, he might at first confound the patient's condition with hebephrenia.

Treatment of essential or idiopathic epilepsy gives variable results. As might be expected, endeavors in the line of prevention are preferable. This means psychotherapy. If the patient can be treated before morbid symptoms appear, that is, while he is still *epileptoid*, not yet epileptic, a great deal of improvement may be reasonably expected in many instances. The epileptoid character is apparently not as often in evidence prior to epilepsy as the schizoid is prior to schizophrenia, or the cycloid before manic-depressive psychosis, or the hysteroid before hysteria. But an early clue may be furnished by the brain-waves recorded by the electroencephalograph.

Patients whose epileptic symptoms appear mainly in the mental sphere (*psychoepilepsy*), including those given to *petit mal* attacks, are frequently helped to a greater or lesser degree by psychotherapy.

When physical manifestations preponderate, psychotherapy is considerably less effective. The organic visceral complaints (heart, lungs, stomach, intestines, etc.) and sensory troubles (flashes of light, buzzing in the ears, peculiar sense of smell and taste, various skin-sensations) are scarcely influenced by psychotherapy. The same may be said about the *grand mal* attacks. There is a modicum of satisfaction, however, in the fact that a *sincere interest in the patient's attacks and his ways of living often makes life in general more bearable to him and his attacks less severe*. Perhaps it is the physician's wholeheartedness of effort that appeals to and helps the patient. The epileptic wants something done for him, whether it be enthusiasm for a dietary regime, for some mechanical device, for a new medicine for which notable claims are made, for some surgical procedure, for psychotherapy, for anything to which he can turn optimistically, whether there is or is not scientific validity backing it.

Sedatives have been used profusely on such patients but the over-all picture has not changed. To be sure, they help a little, their effect being re-enforced by the spirit with which the epileptic takes them.

Alcohol and Other Drugs

Whether the sedative taken by an individual is in the form of alcohol or pills, such as bromides, morphine, opium, marihuana or any of the other well-known agencies inducing sleep or some grade of it, there are always two major factors to be taken into consideration. From the standpoint of pressing need, the effects of the drug should be attended to first, but the basic treatment is of the drug-taking person. *The effect of alcohol (and other drugs) are but symptoms, like headache, dizziness, nausea, pain in the abdomen, weakness, etc.; they are signals that something is wrong, but, in themselves, they do not constitute the disease or disorder.* If the symptoms alone are treated, it is tantamount to treating the headaches of a brain-tumor or the pains of a stomach ulcer, with complete neglect of the tumor or ulcer itself. *The person who drinks, and not the drink, is his own brain-tumor or ulcer, so to speak.*

Many attempts have been made to classify drunkards according to personality types, such as schizoid, cycloid, hysteroid, epileptoid, etc., but drunkards do not seem to fall predominantly into any personality category. They are scattered irregularly among all groups, which gives us the current feeling that any type of person who is finding it difficult to maintain cordial relations with himself and others may find refuge in alcohol or other drugs.

Alcohol provides a mask that conceals the troubled mind. The schizoid individual may take alcohol in order "to loosen himself up" so that he may meet reality with less tension, less fear. Through its narcotizing influence, alcohol gives a temporary boost to the individual's desire to be sociable, to be unafraid of his inner self, to be unafraid of people, to feel less inferior before himself and

others. The shut-in person who is striving with might and main to check the further course of shut-inness, that is, to prevent his own regression to some earlier ways of adaptation or at least to build up some measure of plausibility for giving vent to impulses which he and his associates might excuse only as resulting from alcohol—such a person is teetering between normality and schizophrenia. The more alcohol he consumes the less does the mask of its making serve the purpose of covering up the deeply lying impulses that are constantly crowding for expression in reality. As the schizoid comes more and more under the power of alcohol, conscious control of alcohol is progressively lessened. It is as though the person taking the alcohol said to his impulses: "I can't control you any longer; I'll give you your freedom, but first I must at least have an alibi acceptable to my friends as well as to myself. I don't like you any more than they do, yet if I look the other way perhaps I won't see you coming from me. I don't want people to know that you really are a part of me; indeed, I wish you weren't. But, I have no alternative, so I'll set you free, hoping that I, too, may get some pleasure out of your behavior. Being drunk, however, I can't be responsible for what you do."

The schizoid alcoholic individual, who drinks as an outlet for his inner tensions and the unconscious impulses for which the tensions stand, may and not infrequently does gain an outlet for those impulses that he cannot face without the dimming effects of alcohol or some other drug that curtains his eyes to the impulses. There may be considerable truth in the synonym *shut-eye* for alcohol. The schizoid individual, let us say the one struggling with homosexuality, may gain some measure of temporary escape from it by establishing relations with women through the facility of alcohol or other sedatives. Some become sexually potent through it, though in respects other than sexual they are cold, perhaps ugly, to women. Others use alcohol as the agency through which they give vent to abuse (sadism) upon women. Still others unburden their homosexuality through alcohol, because the alcohol blurs their identification of the woman as a woman, causing them to see her as a man. This is by no means an uncommon occurrence.

We know how relatively easy it is for the schizoid person to make reality what he wishes it to be and he often makes a man out of a woman. Frequently a male patient can fall in "love" with a woman only when he can develop the feeling that she is a man. The patient may know very clearly what he is doing. He may deliberately call her by a masculine name and even ask her to be a "big brother" to him. If she, too, is homosexually inclined, the "love" affair is gratifying to both.

The same general situation may prevail with respect to homosexual women in their relationships with men, whom they castigate and often psychologically emasculate. Psychiatrists see this happening with some frequency. They know that alcohol is not the cause; in fact it occurs more frequently without alcohol than with it. *Alcohol merely facilitates the inversion of sexuality.*

The male schizoid who is predominantly homosexual may prefer to drink only with men. He can then converse freely with them and engage in homosexual practices without being bothered too much by his actions. There are many kinds of reactions on the part of the schizoid individual to homosexuality. (1) To some it is a pleasurable act, for which they need no artificial sedative, such as alcohol. (2) To others it is also quite agreeable, but to enjoy it to the fullest extent they need some conscience-dimming. (3) Then there are those who react against their latent homosexuality. They can escape it and get it at the same time through the development of the paranoid reaction, as was shown in Chapter 14. (4) Others who may resent it may live it out through alcoholism, though they still object to it. The conflict mounts in them until they, too, go into a psychotic state, which in the beginning is so thoroughly soaked with alcohol that they appear to be more alcoholic than homosexual. In many such patients, the symptoms of schizophrenia come into full view when the symptoms of alcohol have disappeared. Diagnostically the name *alcoholic psychosis*, *acute hallucinosis* is given to this, the last and fourth group. The symptoms are divided into two categories, those due to the alcohol and those due to the homosexual conflict.

In alcoholic psychosis, acute hallucinosis, the alcoholic symptoms

are intellectual impairment, including loss of orientation for time, place and person, memory losses ranging from retention of stray events to total amnesia, reduced capacity to comprehend things said to them, fluctuating ability to concentrate, faulty judgment, and emotional instability. Other physical symptoms such as nausea, vomiting, diarrhea, headache, dizziness, neuritis—a host of other symptoms is possible—are as a rule present. Then there are the mental or psychical symptoms, which, in the case of the homosexual individual, are commonly made up of delusions and hallucinations of persecution founded upon homosexuality. The patient fears that he is being followed by men who intend to attack him sexually. He may hear his persecutors referring to him as a "fairy" and making plans to use him as a woman. When delirious, he shrinks in terror from their imminent assault.

In instances of *acute hallucinosis* there is not the same slowly developing and systematic arrangement of homosexual symptoms, rather they come suddenly in disorganized fashion, scattered helter-skelter among the physical symptoms due to alcohol. While the effects of the alcohol are wearing away, the course of the delusions and hallucinations may vary. The mental symptoms may pass away simultaneously with the physical ones. However, the former may outlast the latter by weeks or possibly months. In some instances the mental symptoms go on indefinitely, whereupon the diagnosis is schizophrenia.

Up to this point we have seen the schizoid person's reaction to alcohol. With him alcohol is often taken for its value in socializing him. He may gain just that much by drinking; he may also retain moderately well his general sense of propriety, though usually his chief, underlying conflict may now and then put in an appearance. If his conscious conflict is with heterosexuality, alcohol may lessen or modify it. If it is with homosexuality, alcohol may facilitate it, by overt homosexual acts or by a psychiatric state that stands for homosexuality. Some schizoid, basically narcissistic individuals become selfish under the influence of alcohol. Childish in their desire for attention, they are petulant when not receiving it; they want to be the center of attraction and they often brag with child-

ish vanity. Others may give vent to grandiose phantasies, heavily schizophrenic in nature.

Alcohol is not the sum and substance of alcoholism. The person who takes the alcohol is the central theme of alcoholism. To run through all possible manifestations seen under the influence of alcohol and other sedative agents is to repeat all over again the contents of this book. The cycloid individual, who has the potentiality for manic-depressive psychosis, may drink in order to escape the peak of his emotional troubles. In so doing he may or may not tide himself over an imminent attack of mania or melancholia.

When his symptoms press a psychoneurotic individual too severely, he may find temporary "relief" in alcohol or some other form of narcosis. What is in the individual's mind before he ever starts drinking is his outstanding cause for taking alcohol. This does not mean that alcohol has no individual effects of its own, which it certainly has, but in the matter of fundamental treatment the personality has the prior claim.

There are several more or less well-circumscribed sets of symptoms associated with alcoholism. In delineating these syndromes no effort will be made to describe personality changes for the reason that this would entail a recapitulation of what has already been said.

1. The mildest form of alcoholism that acquires the status of abnormality is called *pathological* (relating to a diseased condition) *intoxication*, the principal symptoms of which are loss of orientation for time, place and person, fragmentary memory, sometimes a state of great excitement, somewhat resembling a manic phase of manic-depressive psychosis; some patients may seemingly be still aware of their surroundings, but later it is found out that they are completely *amnesic* (forgetful) for a longer or shorter period. At times the excitement may take the form of aggressiveness up to the point of homicide. The condition is then called *mania a potu* (madness from drink).

2. Another form of pathological intoxication is known as *dipsomania* ("thirst mania"), characterized by *periodic* drinking. Generally the patient knows why he drinks at intervals; he ordinarily

connects the drinking bout with sadness, moroseness, as so often happens when gloom is impending. *Many psychoneurotic, schizophrenic, and epileptic patients take to alcohol when their troubles seem unbearable to them.*

3. Individuals who drink to intoxication at frequent intervals, say once or twice a week for years on end, are apt to experience *delirium tremens*, particularly after a debauch lasting many days. This condition usually occurs after the age of thirty and is often occasioned by the sudden withdrawal of alcohol from a chronic drinker. That is why it is sometimes called *abstinence delirium*, although by the expression "sudden withdrawal" one may mean abstinence for several days only. Ordinarily for weeks before the onset of the delirium the patient complains of weakness, unsteadiness, restlessness, lowering of concentration, perhaps nausea and loss of appetite, insomnia, and terrifying dreams.

Just before the attack the foregoing symptoms grow worse and to them is added fearfulness, of what—the patient usually does not know. He startles easily with the slightest sound. During the night he may be suddenly awakened by a fearful nightmare; he shudders in horror. During the daytime fear grips him violently and he runs to everyone for protection, because he feels that he is being attacked and his life is at stake. He is sorely troubled with illusions, that is, *with false interpretations of real objects*. If there are colors on the screen placed around his bed, he feels certain they are animals or other living things approaching to kill him and he frantically scrambles to escape. He may have visual hallucinations that have the same fearful thought content. He may see snakes, rats and other awesome animals about to attack him.

Illusions of touch (*tactile or haptic illusions*) are not uncommon, the patient misinterpreting abnormal skin sensations, which seem to arise from the nerves. He may feel that animals or bugs are crawling over or beneath the skin. Illusions of hearing, or times hallucinations of hearing, may form a prominent behind which is again the dread of being attacked and killed. may attack any person in his presence on the assumption that is protecting himself or he may attempt suicide to escape his

mentors. While the mood is usually one of great dread, sometimes its grimness is ludicrous to the patient himself. He may laugh, as if he recognized how ridiculous the whole situation is.

At the peak of his illness he is ordinarily without appreciation of the sense of time, place or people about him. His speech is generally disjointed, incoherent and fearful. He is quite unable to carry memory impressions from moment to moment. Often what he thinks about and reacts to is the result of stimuli from without, which make him very suggestible to the environment. If told that he is in a restaurant and eating, he may believe that he is. A total stranger may be identified as a formerly close pal, if he is represented as such to the patient.

There are coarse tremors chiefly of the fingers, tongue and facial muscles. The pulse is elevated, the patient is weakened and may perspire freely. Often there is a slight rise in the body's temperature. The pupils are usually dilated and their reaction to light may be sluggish or absent. The tendon reflexes may be diminished or absent. The skin is pale; the patient is below his usual weight, appetite is poor and bowel movements irregular.

In the vast majority of instances, the worst features of the illness last from four to seven or eight days. Convalescence may be relatively rapid, though usually it is protracted. The real danger comes not alone from the symptoms of delirium tremens, but particularly from *exhaustion* or heart collapse or pneumonia.

Treatment during the phase of delirium tremens is concentrated upon the physical symptoms caused by the alcohol. The mildest form of sedation—to give rest to the mind and body—should be immediately started; the patient should be placed on a nourishing and easily digested diet, rich in vitamins as well as calories. If there are complications such as trouble of heart, kidneys, or lungs, they should be appropriately treated. During convalescence it should be borne in mind that the whole attack represents but an episode in a fundamentally weakened person, in one whose emotional adjustment to himself and to others is radically faulty. Theoretically the psychiatrist knows where the trouble lies and of what it consists, but in almost all cases the physician's implementation of

professional skill falls astonishingly short of helping the patient.

There are certain individuals, chronic alcoholics among them, who seem to be able to face the *effects* of their abnormality with less distress than they can face the *causes*, their inner selves. For a time they follow instructions of the psychiatrist to the letter, in that they lay bare the events of their past and their unconscious impulses. They honestly vent all that is accessible to them, but they give it out as something that did not belong to them in the first place. *They do not see it as a part of themselves*; it does not sink in, so to speak, not even, for example, the most vivid relationship between an unhappy life and alcoholism. *In psychotherapy it is not enough simply to bare the unconscious; the patient must see the material as his; he must feel that it is a part of the fabric called his personality, his mind*; he must establish correlations with each individual part and, above all, he must redistribute his emotions, putting the right ones in the right place.

4. The alcoholic patient who has had a series of attacks of delirium tremens runs the risk of acquiring a far more chronic disorder called *Korsakoff's psychosis*, so named from the physician who first described it as a clinical entity. Some authorities liken it to chronic delirium tremens, usually without the element of fear and illusions and hallucinations. The major brain symptoms are loss of memory and the tendency to fill in the gaps of memory with real events, but ones which the patient actually did not experience. The state of memory is well-illustrated by the story of two Korsakoff patients. The first one says, "My name is Jones," to which the second one asks, "What is your name?" and the first one retorts, "Who?"

As a rule, the patient has a ready answer for every question. When asked for the date he promptly gives it, though it may be and usually is, months or even years away from the correct answer. Although bedridden for the past year, he may honestly say that yesterday he visited his sister who lives hundreds of miles away and he recounts all that took place while he was . . . This form of mental activity is called *confabulation*. Usually disoriented for time, place and person, though some patients

Korsakoff's *psychosis* can remember certain incidents to which they have been habitually exposed. However, they are easily confused; if a new person appears, it may be months before the patient may repeat the new person's name correctly twice in succession. He may show what is called *perseveration*. If, for example, he last spoke to Jones, then the name of everybody since then is Jones. If he last mentioned some little event, then when asked about any topic, he repeats the same event.

The Korsakoff patient may or may not have illusions or hallucinations; the very deteriorated ones usually have both. The mood is variable; one moment it is affability; the next, irritation; the third, sadness and so on.

Neurological signs are common, the most current being a neuritis affecting one or more of the nerve trunks. There is tenderness and pain over the affected nerve trunk. Sometimes there is paralysis, especially in the form of wrist-drop and foot-drop. One or more of the eye muscles may be paralyzed and nystagmus is commonly observed. Tremors are usually pronounced.

5. Another group of alcoholic patients shows a slowly progressive decline in intellect, character and, as a corollary, in social, professional and recreational endeavors. These people are chronic drinkers, again on the basis of faulty character construction, and show slight but steady physical and mental decline, not altogether dissimilar to that commonly witnessed in old age. Memory is impaired, its loss being most marked for recent events and least disturbed for the distant past. In the early years of *chronic alcoholism*, as this condition is called, the memory losses and—as a consequence—the interruption of the individual's general efficiency, may be concealed by him, but eventually they become quite noticeable.

The moral sense usually declines also, the patient dropping to lower standards as the years go by. He spends his time in happy companionship with people of his kind. He may for a time have held a well-paying position but, with the years, he accepts and works irregularly at menial tasks. He becomes totally neglectful of his wife and children, often becoming abusive to them, when they do not provide him with money for drink. He is *totally un-*

reliable in the accounts he gives of himself, telling lies glibly to his convenience.

Not infrequently he develops delusions of his wife's infidelity. On the basis of the delusions he may thrash her brutally. ^ perversions may later set in, appearing in the form of sadism homosexuality or incest with his own children or sexual play with other children.

Physical decline parallels the emotional and intellectual decline. There is usually a widespread degeneration of tissues of the body, slowly growing worse over a period of many years and becoming complicated, around the age of fifty or later, with hardening of the arteries or with symptoms of premature senility.

Antisocial People (Psychopathic Personalities)

The psychiatric patients who have been described thus far have morbid impulses and symptoms that stamp them as emotionally ill individuals. They have not been against society; they have not hated people or intentionally employed subterfuges to gain their ends. They have been plagued by their own symptoms, which have handicapped them in their longing to be happily associated with others.

There is, however, another category of individuals who live out their morbid impulses more or less directly upon the environment. *Their impulses are not changed into symptoms*, as they are in psychiatric patients, but are acted out directly upon the environment. Law and medicine separate the members of this group, the former particularly holding the individual responsible for his acts. To the psychiatric field this person, who is known by the diagnostic term *psychopathic personality*, is still an object of research and the question of his legal responsibility remains undecided. Because the members of this category vary so much in the intensity of their acts and impulses, it appears unwise to make general statements apply to specific cases.

The person who is known as a psychopathic personality is usually antisocial in his actions. Ordinarily he does not act without conscious knowledge of the fact that what he is about to do is prohibited by law or custom. It is not quite correct to say that he responds to an uncontrollable impulse, because very often the impulse can be checked by the presence or appearance of law-enforcing agencies or by other circumstances which the individual believes may bring him into the hands of the police.

It seems a paradox that this individual is called psychopathic, whereas *the usual symptoms or signs of psychopathy are absent*. This inconsistency appears to be due to the fact that *the diagnosis is not based upon symptoms*, as we commonly understand them, but upon the inner impulses from which symptoms ordinarily arise. There are analogous examples in the practice of medicine to justify such a point of view. A patient with the classical symptoms of appendicitis may be operated upon. During the operation the surgeon when looking around detects an abnormal state of one of the kidneys, say, a congenitally deformed one. A diagnosis is made to fit the condition, though it gave rise to no symptoms at all. To all external appearances the individual is normal, save for the symptoms of appendicitis. So it is with the person we call a *psychopathic personality*. He is neither a psychoneurotic nor a psychotic patient; neither is he suffering from any organic disease, nor is he feeble-minded, so as not to know the nature and quality of his act.

In almost every state in the United States the guiding principles as regards responsibility for one's actions are embodied in what is called *the M'Naghten (or McNaughton) rule*, which in New York State reads that "an act done by a person who is an idiot, imbecile, lunatic or insane is not a crime." A person cannot be tried, sentenced to any punishment or punished for a crime while he is in a state of idiocy, imbecility, lunacy, or insanity so as to be incapable of understanding the proceeding or making his defense. A person is not excused from criminal liability as an idiot, imbecile, lunatic, or insane person, except upon proof that, at the time of committing the alleged criminal act, he was laboring under such defect of reason as:

1. Not to know the nature and quality of the act he was doing.
2. Not to know that the act was wrong.

The foregoing is the so-called test of responsibility. Usually the psychopathic personality is not excused from criminal liability, unless it can be established that he had a psychosis at the time he committed the alleged criminal act. This means that the psychopathic personality may develop a psychosis as may any other indi-

vidual. Thus, there are two subdivisions of this classification, (1) psychopathic personality without mental disorder, and (2) psychopathic personality with psychosis.

1. PSYCHOPATHIC PERSONALITY WITHOUT MENTAL DISORDER

In the first group, *without mental disorder*, the new classification approved by the Council of the American Psychiatric Association lists four subgroups: (a) with pathologic sexuality, (b) with pathologic emotionality, (c) with asocial or amoral trends, and (d) mixed types.

(a) Those with *pathologic sexuality* may be rapists, sadists, sodomists, pedophilists, exhibitionists, homosexualists, and so forth. These sexual perverts assault or molest other persons who resist their advances. The perversion does not appear to be a part of a more extensive mental aberration; it does not seem to be prompted by an irresistible impulse, such as full-fledged compulsion or a delusion or hallucination. It has the quality of deliberation, forethought and planning. It can be deferred until such time as the act may be carried out without detection or apprehension. The individual knows that the act is illegal.

(b) Those who are said to show *pathologic emotionality* may exhibit a variety of emotional responses, which are usually held under control in the presence of superior strength or a police representative. Their commonest pathologic emotion is pugnacity. These individuals are of the bullying type and scorn the rights of others. They elbow their way through groups without any thought of civility and they strike out with their fists without provocation, often grinning at the distress they cause.

They may show their pathologic emotionality by inordinate bragging and tall fables of deeds of toughness or of heroism on their part. Sometimes they act the part of beggars in order to gain money or favors and their plea for alms or assistance seems very real. Others may enact sadness for purposes of attention. There is a *slyness* or *cunning* to almost all of them. They learn how to

live without conforming to the standards of the community in which they find themselves, and they have no compunction as to the methods they employ.

(c) Among those with *asocial or amoral trends* are found the liars, cheats, swindlers, robbers, impostors, forgers, panhandlers, vagabonds, gamblers, panderers, arsonists, extortionists, and so on.

(d) Rarely does the person with *psychopathic personality* fit into only one of the three foregoing subdivisions. Diagnosis is usually made on the basis of the most outstanding deviation. Those individuals, having a number of equally important antisocial tendencies and acts, are said to show the *mixed form* of psychopathic personality.

Malingering is the conscious simulation of symptoms of illness with the intention to deceive. Psychiatrists in private practice and those in civilian psychiatric hospitals see very, very few cases of malingering, because it *rarely occurs in patients with a mental disorder*. When seen it is likely to be associated with psychopathic personality without mental disorder.

Very rarely are *psychopathic personalities without mental disorder* susceptible to any current forms of psychiatric treatment. There may be at least four causes operating against psychiatric effectiveness. (a) Very few have thus far been taken to psychiatrists *who are free to study and treat the individual* from a medical point of view; usually the psychiatrist has to feel as loyal to the community as he does to the patient and this two-sided responsibility warps his application of psychotherapy. He should be mindful of society and of the person, but this dual ethical obligation is conducive to an uncertain frame of mind. The psychiatrist has to take some kind of a stand when the school authorities say that a certain boy lies, steals, fights and upsets classroom discipline. If the physician tries to assume the role of a school principal, the boy dislikes him and will not confide in him, whereupon psychotherapy is hamstrung.

(b) The average psychopathic personality does not reach the psychiatrist before he has committed a criminal act and by that time he has already sworn himself to secrecy. He will not talk,

because he cannot permit himself to trust a psychiatrist who earns his livelihood from the very community that hires him to protect its members from individuals like the offender. The local prosecuting office and the judiciary would surely cooperate to convict him if they knew he has always been antagonistic to society and authority, and had previously committed criminal acts known only to him.

(c) Should a *psychopathic personality without mental disorder*, hailed before the courts, actually confront a psychiatrist, even if treatment might still be instituted, the psychiatrist's position is anomalous: his hands are tied. Selected as he is by the local authorities on the presumption that he will help them legally, he can see no practical way for withholding from the courts the information the prisoner gives him. There is no privacy, no privileged communication. So the proper conditions for psychotherapeutic study are wanting. Attempts to remedy this situation are already under way in many communities, where essentially "nonlegal" facilities have been set up for the study of delinquents. These are more or less genuine research projects, the results of which are not yet sufficiently established to warrant convincing conclusions.

(d) Apart from any restrictions which he feels come from his environment, *the psychopathic personality in and of himself, is difficult to move emotionally by any method of psychotherapy*. By nature he is cold and distrustful and he seldom "loosens" up. Exceptions have been known, but they are few. He may uncover his past experiences in minute detail, but he does so with a more or less uniform emotional reaction; his attitude is that it was his tough luck to have had the experiences, but he is not complaining—he has previously taken care of himself and he can continue to do so. If he should be caught in another criminal act, well, he will be caught, convicted, sentenced and he will serve out the sentence without complaint, though, of course, he hopes he will not be caught—that is his response to his entire past. *His true emotions are deeply concealed within him, far from his conscious mind.*

From the person with a psychopathic personality, the psychiatrist often elicits a wealth of information which he can reconstruct into excellent knowledge of the many factors involved in

the development of the psychopathy. However, the psychopath usually remains passive, even when assured absolutely that what may be presented to the psychiatrist is strictly a privileged communication. *Psychiatrists do not yet know how to bring the emotions of the person with a psychopathic personality into contact with his original experiences.*

Ordinarily the psychopathic personality shows evidence of having been such long before coming into conflict with the law. He or she was in conflict with the parents or siblings from early childhood. The parents may or may not have played an important stimulating role in the child's attitude of resentfulness. There is the side of the parents or others who later exercise authority over him, and also the side of the child himself or herself. We cannot speak with certainty, but it appears that the boy who later becomes a psychopath cannot follow the usual course of discipline. He is resentful, unless he is allowed to do things as he wishes and usually he does not wish to follow the long, hard road to success. He undertakes to hurdle the steps indispensable to success, only to land in a mudpuddle a few feet off to one side. The story is identical in the home, the school, the playground, and the workshop.

Psychiatrists have been baffled for years by the people to whom they give the diagnostic name *psychopathic personality*. If the person is psychopathic, does that not mean that his mind is disordered, for *pathic* means diseased. It is a contradiction to claim that a man or woman has a mental disorder without a mental disorder. Current practices, however, compel the physician to state whether a man is or is not mentally sick. Since the standard by which physicians gauge health or disease is the absence or presence respectively of *symptoms*, and since symptoms in a purely medical sense are absent in these cases, the person is said to be in a state of good health. Being in good health, he is responsible for his actions.

Legal difficulties arise when the physician, going outside of the strictly medical realm for his definition of health and disease, uses *sociological or cultural standards* by which to arrive at an opinion. In so doing he is traditionally and legally in error. Yet, it is easy to appreciate why he often defends the psychopathic personality.

In the final analysis, psychopathic personality represents emotional immaturity and that is academically well within the province of medical practice. Practically, however, it is not so; if it were, then all the deviations from law and order would have to be measured by medical standards. The medical field is not qualified to defend, or to render sound judgment with respect to, lawbreaking citizens, unless at the time that the citizen broke the law, he had symptoms, recognized by the law as falling within medical classifications. Even when symptoms are present, the law requires that, to absolve a culprit, it must be shown that the symptoms, not the culprit, were responsible for his act.

From the psychiatric point of view, the psychopathic personality does have symptoms. His acts—lying, stealing, truancy, pandering, down the full list—are symptomatic of emotionally distorted growth. The psychopath, who “without provocation” is antagonistic and assaultive to older men is, without his knowing it, merely displaying upon other men his underlying hatred of his father. It is his symbolic way of giving vent to an unconscious complex.

Analysis shows, too, that robbery, for example, is not without its unconscious determinants. As a rule, robbers specialize in certain ways of robbing. Some will rob only men, and then, only men while they are at home; others rob only stores, sometimes only at night, when no one is in the store, sometimes only during the day, when the proprietor is there. Still other robbers will break into a store only by way of the rear entrance, while some will not enter except through the front transom.

This list could be extended almost indefinitely. The fact is the people with so-called psychopathic personality, are “emotional specialists,” so to say. They are different from the out-and-out psychiatric patient, not in their motivations, but in the manner by which their motivations are lived out.

2. PSYCHOPATHIC PERSONALITY WITH MENTAL DISORDER

Individuals known as *psychopathic personalities* are susceptible to more or less clearly defined mental abnormalities. Studies to date

indicate that their commonest psychiatric disorders are psychoses. Some of them develop clear-cut states of manic-depressive psychosis, though, perhaps, states *resembling* manic-depressive psychosis are the rule. A somewhat similar situation prevails with respect to schizophrenic disorders in psychopathic personality.

The frequency of psychoneurotic conditions in psychopathic personality is not as clearly known, though such disorders have been established in connection with it. The whole problem of psychopathic personality clamors for additional research. This is a broad field, about which psychiatrists have insufficient information.

There are three special sets of symptoms that are found more frequently among psychopathic personalities than among other types of individuals. (a) One is the so-called *prison psychosis* (sometimes called "*stir fever*" in the inmates' vernacular) which is not any one type of psychosis, but is a psychosis developing in individuals serving sentence for some criminal act. The prisoner's main preoccupation is his detention, which he believes to be unjustified or which he thinks has brought ineffaceable disgrace upon him and those dear to him. Whatever his reason, he may strive to erase from his memory the imprisonment and all that led to it. When he can do that only by falling sick with a psychiatric disorder, the nature of the psychiatric syndrome depends upon the type of personality that is so afflicted. Under the duress of imprisonment, the individual who, prior to the commission of his criminal act, was cycloid in personality, may develop manic-depressive psychosis. If he was schizoid, schizophrenia may result. If he was *psychoneuroid* (*resembling* psychoneurosis), he may develop one of the kinds of psychoneurosis.

(b) *The Ganzer syndrome* is often observed in a prisoner, usually while held for trial, though it may set in during the trial, or after conviction, or after sentencing. It is believed to represent a defense against conviction and sentencing, and as such to be partially at least a conscious process. It is sometimes known as the *syndrome of approximate answers*, because the prisoner always answers questions with relevance to the general topic, but faultily as to details. When shown a 25-cent piece he names it as a dollar or a dime; when

shown a pencil he says it is used in writing, but he never designates it correctly; a necktie is a piece of wearing apparel; a shoe is a foot-covering. He writes three when asked to write two; raises the left arm for the right; steps backward when requested to go forward. His general attitude is one of immobility, not dissimilar in appearance from that seen in catatonia, although its resemblances to hysterical pseudo-dementia are frequently noted.

(c) A third syndrome associated with psychopathic personality with mental disorder is known as *pseudologia phantastica*, meaning false and phantastic recitation of some event. At the time, the individual believes the account to be true. For instance, he may give full and complete details of some act of heroism in which he believes he participated. He may parade as a military hero or a captain of industry, or a desperado, conceiving himself to be really one or another. The patient usually recovers from the episode and later possesses insight into it.

Emotions and Intellect

It is customary to think of man from three broad points of view—(1) the physical, (2) the human or personal, and (3) the intellectual. These aspects are by no means distinct and apart. Each has its own individual laws, but the three together coordinate their special functions in behalf of the over-all activity of the individual. Their combination enables man to be a part of the environment in which he lives.

The energy system of man is called upon to put any one or all of these three sides—the physical, personal, and intellectual—into use and action as his needs arise. When the demand is for physical activity, the energy is concentrated in the body. In order to meet fully an emergency need for exceptional physical activity, the body may draw energy from the two other zones, the personal and the intellectual. So, too, can the intellect and the personality obtain energy from the physical system whenever they are in need of extra energy.

This give and take, this mutual cooperation, is what helps man to run smoothly as an *in toto* organism. However, several conditions must first be met before the organism can function easily.

1. In the first place, there must be an *adequate supply of energy* upon which to draw. The science of man has not yet provided much information on the source and quantity of energy within the individual, but from observation we have learned that not all humans are born equal from the standpoint of energy. Some seem to have more than others, some less, some approximately the same quantity. When we finally have come to know this most funda-

mental problem in the biology of the human organism, it is not improbable that a totally new biological era will open up.

2. In the second place, there must be an adequate supply of *the right kinds of energy*. At the present time, we recognize two kinds of energy. At least, that is the way we speak about what we see. The one is *anabolic*, meaning that it serves the purpose of *building up*; it is *constructive*. The other is *catabolic*, that is, it is engaged in the process of *tearing down*, of *destroying* and *removing*. These two processes, together called *metabolism*, go on continually from the very beginning to the very end of life.

Whether they are separate forms of energy, or the same energy applied to different tasks, is not known. Nevertheless, observation compels us to distinguish between the two.

With full appreciation of the incompleteness of our information we set up the hypothesis, which seems to serve practical exigencies, if not scientific requirements, that all individuals are not born with these two forms of energy share and share alike. Maybe they should not and need not be equal; we are groping in the dark, yet must get along with the facilities at hand.

Whether this is correct or not, it appears that some people have a much greater supply of one form of energy than of the other. Some seem to keep adding to their strength, others to keep failing. But, they are those two features of energy that seem to play a fundamental role in the total economy of the individual.

3. In the third place, if we grant that the person has (a) adequate energy and (b) adequate anabolic and catabolic energy, there is still another requirement for the smooth running of the organism. That requirement comprises *the energy-needing parts of the organism*. As already mentioned, there are three main units or systems— (a) that which we call the physical, including organs such as the heart, lungs, muscles, etc.; (b) that which we call the human or personal, embracing personality traits, likes and dislikes, personal experiences, etc.; (c) that which is known as the intellectual, embodying the processes of learning, which in general comes under the heading of scholarship. When we say a person is brilliant,

or dull or ignorant, we usually have reference to what he has learned, as well as to the way he sizes up and makes use of what he has learned.

We have in mind these three systems of man when we say that (a) he is healthy or sick; (b) he is pleasant or disagreeable; (c) he is bright or stupid.

All people are not born equal with respect to these three systems. Physical forms and functions as well as those of personality and intelligence vary widely from one person to another.

If the individual's energy, however adequate it may be in itself, is applied to a structurally impaired system, some degree of faulty operation is inevitable. When we realize that each of these three great systems must undergo radical changes in its evolution from the one-celled up to the billion-celled stage; when we appreciate that each system in itself must differentiate into many and varied parts, it is not difficult to understand that all parts may not develop to a degree of maximum efficiency.

Hence, the well-running organism depends upon (1) the nature and quantity of its energy and (2) the structural condition of the apparatus to which the energy is supplied.

4. In the fourth place, *training or conditioning* is of considerable consequence to biological economy. A potentially adequate physical system and for that matter a potentially sound personal or intellectual system may suffer from relative disuse or abuse. The conditioning of energy to meet the needs of successive periods of growth is surely a momentous task. It would be just that, even if man were born *de novo*, so to speak. The job of fitting an individual into new and untried situations is rendered all the more difficult, because a newlyborn has often so strong a degree of *conditioning by nature*, that all efforts of society (parents, teachers, etc.) are to a greater or lesser extent unavailing. We human beings strive to accomplish within a few years a more or less complete reversal of a set of conditions to which man has been inured for millions of years. All in all we do a rather good job of it, though we are still mere apprentices.

All of the foregoing is in the nature of a preface to the title of

this chapter, "Emotions and the Intellect." Such an orientation seems to make the approach to the intellect somewhat easier. But, first, we should try to find out what the intellect is.

In previous chapters we studied the origin and development of energy as it was distributed among the many units of the *mind*, stressing the course of energy as it passed from the body to the *Id*, thence onward to the *super-ego*, *ego* and the environment, or, more correctly, the concepts which the individual acquires concerning the environment. Strictly speaking, this is *mental* energy, that is, energy associated with the mind or personality, or those qualities that comprise the personal and human aspects of the individual.

Now we shall focus our attention upon the *intellectual* attributes, attempting in passing to gauge their use by and meaning to the individual. Before we do that, however, we should settle what we encompass by the term *intellect*.

To define or to describe what we mean by this concept, is not easy, perhaps, because the mind, body and intellect are so closely interrelated, and, until further research clears up this interrelationship, it might be advantageous to set the intellect apart for practical purposes of study, much as we might study any organ of the body alone, but certainly without forgetting even for one moment that every organ and possession of the human being is also part and parcel of other organs and possessions. By "possessions" or assets we mean emotions, ideas and experiences, those attributes often referred to as functions whose organic, structural seat is as yet unidentified.

The simplest statement we can make, then, is that *intellect* is a function, the task of which is to receive, store up and use the so-called learned or acquired facts. The data are derived from many sources in the environment, the educational system being the richest and best-organized source.

The intellect's *capacity* to perform one or more of its functions varies from individual to individual. Apparently the *capacity* is *inborn*. When the capacity is very great, as it seems to be in slightly over one per cent of the total population, the person is

said to be *gifted* and has what is called an *Intelligence Quotient* of 141 or better.

Normal intellect, that is, one neither superior nor inferior to the general run of individuals, is represented by an Intelligence Quotient (I.Q.) ranging from 91-110. It has been estimated that approximately 46 per cent of the population come within the *normal* range.

Just above the *normal*, constituting about 23 per cent are the *superiors*, with an I.Q. ranging from 111-120; above them, totaling about 15 per cent, are the *very superiors*, the I.Q. being from 121-140, while the highest are the *gifted*.

In descending order is the group called *dull* or *backward*, having an I.Q. of 81-90, making up about 9 per cent of the population. Next below them is the *borderline* group, I.Q., 71-80, comprising about 4 per cent of the population; then come the *Morons* (I.Q., 51-70), *imbeciles* (I.Q. 25-50) and *idiots* (I.Q., 24 or lower). The total of the last three groups in the population constitutes about 2 per cent.

These estimates of the *capacity* are arrived at by applying special tests to the individual. Psychologists have done more than any other group to institute, perform and rate the tests. Examinations designed to gauge the Intelligence Quotient come under the general heading called *psychometry*. Since psychometry is a speciality, requiring high skill, but also because it includes tests relative to the individual's special intellectual aptitudes, it would appear reasonable to recommend that the services of the psychometrist be sought in the over-all examination of anyone who seems to be or actually is having any difficulty from the standpoint of his or her intellect.

When once the *capacity* of the intellect is established, the next important question has to do with the *use* to which the capacity has been and is being put. For the general individual's adaptation the problem of *use* or *function* is very often, save among those who are moronic or lower, just as significant as the capacity is.

In keeping with the plan followed throughout this book, we shall consider the intellect, as we did the body and the mind, from the

point of view of energy, keeping before us the concept of its dual nature—constructive (anabolic) and destructive (catabolic) energy. That both forms of energy *normally* use the intellect as an outlet is an everyday observation. In most households a child wins parental esteem when his or her intellect is put to good use. This means also that part of the child's tender, affectionate, constructive, erotic energy is spent in intellectual achievement. Likewise part of the aggressive, destructive, thanatotic energy finds outlet through intellectual channels. We need only mention the child's angry outbursts often revealed in connection with a school problem, which in itself does not warrant the excessive emotions put into it.

This funneling of instinctual energy through the intellectual sphere is merely another way by which energy is conveyed from its original source and manifestations to new and different objects, so to say. Accordingly, there are three main channels through which instinctual energy may flow: 1) the body; 2) the mind; 3) the intellect. The normal, healthy person uses each of these ways, according to the exigencies of the occasion. Departures of instinctual energies from the normal use of intelligence often come under the attention of psychiatrists. The principal deviations are described in the paragraphs that follow.

1. *The greater part of the child's instinctual energies may be directed to and find lodgment in the sphere of the intellect.* Thus learning acquires the distinction of being overloaded, overweighted. There is danger in this unequal distribution of energy, because it means a drawing away of energy from the two remaining fields, the body and the person as a human being. When energy that should find expression in the body or in personal human relations is diverted to the intellectual realm, it is highly probable that the individual will grow up emotionally lopsided.

Such one-sidedness is not uncommonly observed by psychiatrists, particularly when the deeply rooted instincts try to gain outlet through learning or intelligence or scholarship. Sometimes we see a child and its parents held together almost solely by intellectual bonds. The instincts were never intended to be humiliated by intelligence and usually, sooner or later, they break away from such enslave-

ment. In previous chapters it has been repeatedly shown how direful the results of such a breaking-away may be. When the body finally seizes the instincts which rightfully belong to it, it is not satisfied merely to take what belongs to it, but it grabs everything in sight, leaving the intellect bare.

This is hardly overstating the record of everyday observation that the person suffering from a mental disorder cannot think clearly, logically; cannot concentrate on intellectual topics, not because the intelligence itself is damaged, but because it is deprived of the energy needed to help its functioning.

An Oedipus or an Electra complex may sap strength from the intellect, particularly if a parent-child relationship is held together by intelligence. The function of intelligence is thus greatly abused.

Intelligence should be a means to an end, not the end itself; the end is wholesome, well-rounded adaptation as a human being. Many a person in whom the instinctual energies are excessively devoted to intellectual endeavors becomes *functionally* a moron, an imbecile or, perhaps, an idiot.

How quickly one may succumb to *functional feeble-mindedness* depends upon three principal factors: First, upon the original *capacity* of the intellect; second, upon the *use* to which the capacity is put; third, upon the *strength* of the instincts.

The person with a high capacity and full use of it may pass through a long lifetime without being troubled very much. But another person, with the same capacity and use, may succumb to a psychiatric disorder early in life.

Psychiatrists often see patients who shift their doubts, fears, obsessions and delusions from their original source in the unconscious to the sphere of the intellect, thus making it appear to them and to others that their troubles are intellectual rather than personal. This misuse of the intellectual is more or less analogous to the displacement of emotional conflicts upon organs of the body, to which the general name *psychosomatism* is given. It might not be inappropriate to designate the *transference* of the personal conflict to the intellect as *psychonoetism*.

For example, a patient, unknowingly plagued by a strong

Oedipus complex, diverted the energy of the complex from it to the sphere of the intellect. Among other things, he was a great objector. No matter what came into his mind from within or from without, the moment he sensed it, he raised objections, stoutly maintaining it could not be so. Everything was "no, no, no," although he realized that correctly the answer should be "yes." His intelligence indorsed, but his emotions denied. This condition grew so firmly upon him that it was every bit as incapacitating as a real organic disease might be.

Everything was "not so" to him, to the degree that, while his mind was working excessively throughout the waking hours, the result was the equivalent of mental blankness. Proper names, especially, were "not so." He could not be sure that he knew the names of people he had known intimately for years. In his own words, "I'm sure I can't be certain about my own mother's name." Indeed, as psychotherapy progressed, it became clear that his first tormenting "don'ts" were about his mother. It was fortunate, he explained, that he did not have to address his mother by any name, while speaking to her. He recalled, too, that early in his illness he doubted whether she was alive or dead, whether she was single or married, whether her address was what he "knew" it to be. He could not trust his memory of her when he thought back to his youthful associations with her. While his obsessive doubting was in the making, often he would stare at a picture of her in her younger years, but he couldn't make sure it was she.

The obsession to say "no" to everything represented what is called the *negative of the perversion*. Consciousness is saying "no" to the unconscious instinctual demands.

As the conflict mounted, its point of emphasis shifted from the personal to the intellectual sphere. Within a few months of the beginning of the "doubting-mania," the Oedipus complex had so completely shifted over to the intellectual sphere that it appeared as if the patient's troubles were wholly intellectual.

The general principles of psychotherapy are the same for conflicts that are intellectualized as they are for those somatized or symbolized by such phenomena as fears, delusions, etc. The source

of the conflict is the same; the principles of treatment are the same; only the symptomatic pathways are different.

To indicate again the possible fate of energy connected with a complex in the unconscious may help to make the point clear. There are five principal ways by which the energy of a complex may reach the level of consciousness. Any one or several together may be observed in an individual.

(a) The energy, detached from the complex, may be diverted to natural, normal pursuits, that is, it may be *sublimated*. Let us take the part-instinct *exhibitionism* as an example. It is within the normal range of an infant's conduct to show off his or her body, to expose it. As the infant grows up, it is taught to cover its body. The pleasure shifts from the infant's body to its clothes. The pleasure may be further refined (i.e., sublimated) when it is transferred to physical skill in athletics or in dramatics. The motive remains the same—*exhibitionism*—but the object has changed.

(b) The energy, detached from the conflict, may be diverted to the intellectual sphere, that is, it is *intellectualized*. Intellectualization is a form of sublimation. When the child is praised for its scholastic achievements, it lives out some of its exhibitionistic impulses by way of intelligence. The pedant is an extreme example of intellectual "show-offishness."

(c) The energy, detached from the complex, may be diverted to one or more organs of the body, that is, it may be *somatized*. In principle this is what happens in sublimation, but it takes the name *conversion* when it is intended to indicate an abnormal or morbid displacement of the exhibitionistic impulse. The woman who goes from physician to physician for physical examination is satisfying at least one whim—*exhibitionism*, particularly when she is repeatedly told that she has no organic disease.

(d) The energy, detached from the complex, may be lived out through symbols, that is, it may be *symbolized*. The usual psychiatric symbols are fears, obsessions, compulsions, delusions and hallucinations. Exhibitionism, for example, may appear in the grandiose patient who strikes the pose of some historically great person.

(e) The energy of an unconscious complex and the complex itself may appear in their original forms. Exhibitionism may appear as "indecent exposure" or, as in the manic state of manic-depressive psychosis, may be seen in total body nudism. It is then said that the infantile exhibitionism is *directly environmentalized*.

2. *A high intellectual capacity may be only partially used*, giving rise to another form of *functional feeble-mindedness*. In these instances, however, there is less likelihood of an emotional breakdown, particularly since the body and the person take over the energy that the intellect does not use. When such a person falls ill with a mental disorder, it is not so much a question of the *distribution* of instinctual energy as it is of the stuntedness of the instincts, that is, of the objects to which the instinctual energies are attached.

3. *The smaller the intellectual capacity the lesser its use*. The amount of *energy* that the intellect can hold is directly proportional to the capacity of the intellect. In cases of severe feeble-mindedness, one of the most valuable outlets of instinctual energy is absent. The child is in severe straits, because it cannot learn the merest disciplines of infancy. In this child the instinctual energies remain animalistic, to a degree corresponding with the meagerness of intellectual capacity. In him or her there is no well-formed parental code or *super-ego* to guard and direct the instincts. Nor is there a conscious ego or critical judgment that can help the individual handle the instinctual drives from within or the social demands from without.

There is no form of psychotherapy applicable to the instincts in extreme instances of feeble-mindedness. Theoretically the greater the intelligence the better the chances of *applying* one or another means of psychotherapy. The probable *results* of application depend upon factors already described in other chapters of this book.

Whether the patient's psychiatric troubles are concealed in the body (i.e., psychosomatized), or in the intellect (i.e., psychonoe-tized), or are in the mind itself (i.e., intrapsychic), the techniques of psychotherapy are fundamentally the same. In psychiatric patients the energy of a complex is generally distributed to each of the three zones, though one of them usually acquires greater

00—5.0 PSYCHOSES DUE TO DISTURBANCE OF CIRCULATION

Record primary physical diagnosis also

- 003-512 Psychoses with cerebral embolism
- 003-516 Psychoses with cerebral arteriosclerosis
- 009-5xx Psychoses with cardiorenal disease
- 003-5y0 Other types. *Specify*

00—5.5 PSYCHOSES DUE TO CONVULSIVE DISORDER (EPILEPSY)

- 003-550 Epileptic deterioration
- 003-560 Epileptic clouded states
- 003-5y5 Other epileptic types. *Specify*

00—7 PSYCHOSES DUE TO DISTURBANCES OF METABOLISM, GROWTH, NUTRITION OR ENDOCRINE FUNCTION

Record primary physical diagnosis also

- 001-79x Senile psychoses
 - 002-79x Simple deterioration
 - 003-79x Presbyophrenic type
 - 004-79x Delirious and confused types
 - 005-79x Depressed and agitated types
 - 006-79x Paranoid types
- 930-796 Presenile sclerosis (Alzheimer's disease)
- 001-796 Involutional psychoses
 - 002-796 Melancholia
 - 003-796 Paranoid types
 - 0y0-796 Other types. *Specify*
- 00x-770 Psychoses with glandular disorder. *Specify glandular disorder (page 442 of the Nomenclature)*
- 009-712 Exhaustion delirium
- 009-7623 Psychoses with pellagra
- 009-7xx Psychoses with other somatic disease. *Specify disease*

00—8 PSYCHOSES DUE TO NEW GROWTH

Record primary diagnosis

- 003-8.. Psychoses with intracranial neoplasm. *Specify (page 87 of the Nomenclature)*
- 009-8.. Psychoses with other neoplasm. *Specify (page 87 of the Nomenclature)*

00—9 PSYCHOSES DUE TO UNKNOWN OR HEREDITARY CAUSE BUT ASSOCIATED WITH ORGANIC CHANGE

Record primary physical diagnosis also

- 006-953 Psychoses with multiple sclerosis
- 004-953 Psychoses with paralysis agitans
- 004-992 Psychoses with Huntington's chorea
- 004-9y0 Psychoses with other disease of the brain or nervous system. *Specify disease*

0—X DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY DEFINED TANGIBLE CAUSE OR STRUCTURAL CHANGE

- 001-x10 Manic-depressive psychoses
 - 001-x11 Manic type
 - 001-x12 Depressive type
 - 001-x13 Circular type
 - 001-x14 Mixed type
 - 001-x15 Perplexed type
 - 001-x16 Stuporous type
 - 001-x10 Other types. *Specify*
- 001-x20 Dementia præcox (schizophrenia)
 - 001-x21 Simple type
 - 001-x22 Hebephrenic type

- 001-x23 Catatonic type
- 001-x24 Paranoid type
- 001-x20 Other types. *Specify*
- 001-x30 Paranoia
- 001-x31 Paranoid conditions
- 001-x40 Psychoses with psychopathic personality
- 001-x50 Psychoses with mental deficiency¹

PSYCHONEUROSES

See also under organ (Category 1.5)

Hysteria

- 002-x00 Anxiety hysteria
- 002-x10 Conversion hysteria
- 002-x11 Anesthetic type. *Indicate symptomatic manifestations (page 508 of the Nomenclature), e.g.: x12 amaurosis, x06 deafness, 55x anesthesia of . . ., x41 anosmia*
- 002-x12 Paralytic type. *Indicate symptomatic manifestations (page 508), e.g.: 561 monoplegia, 563 hemiplegia, x32 ophthalmoplegia, 956 aphonia*
- 002-x13 Hyperkinetic type. *Indicate symptomatic manifestations (page 508), e.g.: 225 tic (facial or other), 222 spasm, 228 tremor, 20x postures, 936 catalepsy, 934 convulsions, 302 stammering, 301 stuttering*
- 002-x14 Paresthetic type. *Indicate symptomatic manifestations (page 508), e.g.: 506 dyesthesia, 507 paresthesia*
- 002-x15 Autonomic type. *Indicate symptomatic manifestations (page 508), e.g.: 154 hyperhidrosis, 153 edema, 159 ulceration*
- 002-x16 Amnesic type. *Indicate symptomatic manifestations (page 508 of the Nomenclature), e.g.: 901 fugue, 911 amnesia, 917 somnambulism, 936 catalepsy, 902 trance, 903 dissociated personality, 931 delirium, x07 hallucination of hearing, 904 dream states, 933 stupor*
- 002-x1x Mixed hysterical psychoneurosis. *Indicate symptomatic combinations by using the various symptoms included under the different types in this section or those listed on page 508*

Psychasthenia or compulsive states

- 002-x21 Obsession. *Indicate symptomatic manifestations (page 508), e.g.: 905 délire de toucher, 906 counting (steps, etc.), 908 urge to say words, 971 kleptomania, 974 dipsomania, 972 pyromania, 973 trichotillomania, 907 folie du doute*
- 002-x22 Compulsive tics and spasms. *Indicate symptomatic manifestations (page 508), e.g.: 228 tremor, 227 occupation spasm or tic, 226 habit spasm or tic, 224 spasmus nutans, 301 stuttering, 302 stammering*
- 002-x23 Phobia. *Indicate symptomatic manifestations (page 508), e.g.: 983 claustrophobia, 984 syphilophobia, 985 agoraphobia, 986 misophobia*
- 002-x2x Mixed compulsive states. *Indicate symptomatic combinations by using the various symptoms included under the different types in this section or those listed on page 508 of the Nomenclature*
- 002-x30 Neurasthenia
- 002-x31 Hypochondriasis
- 002-x32 Reactive depression (simple situational reaction, or other type)
- 002-x33 Anxiety state
- 002-x34 Anorexia nervosa
- 002-x0x Mixed psychoneurosis. *Indicate symptomatic combinations by using the various symptoms included in this section or those listed on page 508 ff.: 981 anxiety, 982 depression, 0x0 fatigue.*
- 001-y00 Undiagnosed psychoses
- 0y0-y00 Without mental disorder. *Diagnosis to be used in psychiatric clinics. Also in psychiatric and psychopathic hospitals, to account for patients sub-*

¹ For patients over 16 years specify mental level as idiot, imbecile or moron; intelligence quotient (I. Q.) based on 16 year level

mitted for observation or allowed to remain in hospital for other legitimate reason. Record condition also in positive terms, as

- 930-yxx Epilepsy
 000-332 Alcoholism
 000-3xx Drug addiction
 00-yxx Mental deficiency¹
 000-163 Disorders of personality due to epidemic encephalitis
 000-x40 Psychopathic personality
 000-x41 With pathologic sexuality. *Indicate symptomatic manifestations (page 508 of the Nomenclature), e.g.: 991 homosexuality, 992 erotomania, 993 sexual perversion, 994 sexual immaturity*
 000-x42 With pathologic emotionality. *Indicate symptomatic manifestations (page 508), e.g.: 041 schizoid personality, 042 cyclothymic personality, 913 paranoid personality, 043 emotional instability*
 000-x43 With asocial or amoral trends. *Indicate symptomatic manifestations (page 508), e.g.: 044 antisocialism, 047 pathologic mendacity, 046 moral deficiency, 048 vagabondage, 987 muanthropy*
 000-x4x Mixed types. *Indicate symptomatic manifestations by using the various symptoms included under the different types in this section or those listed on page 508*
 0y0-y05 Other nonpsychotic diseases or conditions. *Specify. Use this term for statistical purposes only; diagnose each disease in specific terms according to appropriate section of Nomenclature*

PRIMARY BEHAVIOR DISORDERS

- 000-x61 Simple adult maladjustment
 Primary behavior disorders in children
 000-x71 Habit disturbance. *Indicate symptomatic manifestations (page 508), e.g.: 031 nail biting, 032 thumb sucking, 722 enuresis, 034 masturbation, 033 tantrums*
 000-x72 Conduct disturbance. *Indicate symptomatic manifestations (page 508 of the Nomenclature), e.g.: 04x truancy, 050 quarrelsomeness, 051 disobedience, 059 untruthfulness, 054 stealing, 055 forgery, 056 setting fires, 053 destructiveness, 057 use of alcohol, 058 use of drugs, 052 cruelty, 995 sex offenses, 049 vagrancy*
 000-x73 Neurotic traits. *Indicate symptomatic manifestations (page 508), e.g.: 225 tics, 226 habit spasm, 917 somnambulism, 302 stammering, 006 overactivity, 980 fears*

¹ For patients over 16 years specify mental level as idiot, imbecile or moron; intelligence quotient (I. Q.) based on 16 year level.

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